mental health digest

National Clearinghouse for Mental Health Information, Vol. 2, No. 5, May 1970

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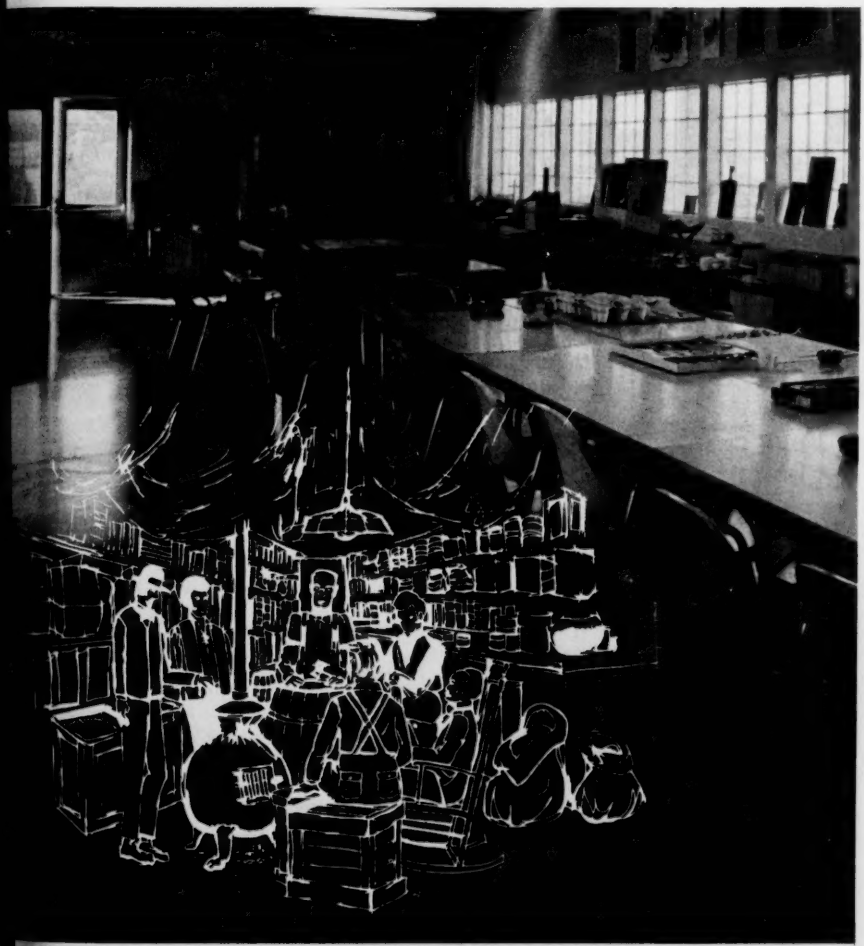

cover story

The Voice of the People

From the town meetings of early New England—many of them held in a general store—to the advisory boards of community mental health centers—which often meet in modern, spacious conference rooms—the people of the United States have worked out their own destinies. Thousands of private citizens are now involved in mental health activities—serving on boards and committees to determine the mental health services needed in their communities; doing volunteer work in hospitals, clinics, and schools; joining voluntary organizations; raising funds; and taking part in the meetings of self-help groups.

mental health digest

The *Mental Health Digest* is a monthly publication designed to reflect the whole spectrum of mental health and to present a broad sampling of scientific subject matter and professional points of view. It contains condensations of material selected from the current mental health literature. The condensations are published with the approval of the authors and publishers for use in the *Mental Health Digest* only.

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Use of funds for printing this publication approved by the Director of the Bureau of the Budget, May 20, 1968.

Citizen Participation in Mental Health Programs

The town meetings of early New England have often been described as the epitome of the democratic processes. Citizens of the town met together to debate, decide, and ultimately vote on all governmental actions. Over the years, direct citizen participation in the affairs of government diminished. But recently citizens throughout the country have been increasingly active in determining the governmental programs in their communities, especially in health and welfare.

The National Institute of Mental Health was the first Federal government agency to identify citizen participation as a discrete program area. Subsequently, this activity was seen in the model cities program of the Department of Housing and Urban Development and in the Social and Rehabilitation Service of the Department of Health, Education, and Welfare.

The citizen is viewed as both a supporter of mental health programs and a consumer representative. In discharging these responsibilities he may be the initiator of services through membership in voluntary organizations or serving on advisory boards. Or he may be the implementer of services through his contributions of direct volunteer activities. His participation and involvement in the betterment of his community may, in itself, be a constructive act toward maintenance of his own emotional well-being. Citizen participation, then, is viewed in the broad perspective of the need for the citizen living in an ever-increasingly complex society to share in the decisions affecting his destiny.

The fact that the "man who foots the bill" has the right to determine the quality and quantity of services has not always been taken into account in planning and delivering mental health services. The professional, accustomed to his lofty role of expert, is comfortable in the role of deciding what's best for the consumer. For the most part, he is unaccustomed to reliance on the citizen for guidance, direction, and program design. Viable models are needed, pointing to effective partnership between professionals and citizens in program development to insure that services meet existing needs.

The NIMH's first formal recognition of the significance of citizen participation in mental health occurred in February 1966 with the designation of an Advisor on Citizen Participation in the Office of the Director. In January 1967, the Citizen Participation Branch was established in the Office of Program Liaison as the Institute's focal point for developing methods to facilitate consumer participation in mental health programs. The Branch serves as a central resource for information, consultation, coordination, and interpretation concerned with effective citizen participation in improving the delivery of mental health services to consumers.

Citizen Organizations

As an initial step, the Branch convened an Ad Hoc Committee of Citizen Organizations which brought together representatives of a dozen major national organizations to advise on methods of effecting closer working relationships and to present special needs of these consumer groups. Two major related themes emerged. One was concerned with obtaining more information on developments in men-

tal health and the other was an expression of interest in increasing citizen leadership in mental health efforts.

Continued followup with these groups, as well as others unable to serve on the Committee, has been aimed at understanding the organizational structure, special needs, areas of interest, and contributions of each of the groups. The Kiwanis Clubs, for example, have concentrated on developing an educational program in the special area of drug abuse. The U.S. Jaycees have designated a national mental health chairman and organized a national seminar for all their State mental health chairmen; they are working cooperatively with the National Association for Mental Health and the Branch toward development of programs which will more effectively reach their local chapters. The Association of the Junior Leagues of America has worked with the Branch on a community services conference and in planning for assistance in a volunteer training program for their members. Consultation has also been provided the National Congress of Parents and Teachers in further refinement of their approach to identifying mental health leadership at county, district, and selected local unit levels.

The Branch has continued the policy of distributing appropriate informational materials to citizen organizations in this country. Special resource material has also been made available for meetings of Jaycees, Kiwanis, Junior League, AFL–CIO, etc.

In assessing national citizen organization involvement in advancing mental health programs in the country, the Branch has identified three groups: Jaycees, the PTA, and the National Association for Mental Health. These groups have selected mental health as a major program thrust and have organized both at national and State levels. The organizational base at local levels varies, with the mental health associations having, in many cases, staff assistance available. The other two groups work through their own organizational components of Jaycee Chapters or County/District Councils of PTA. In recognition of the need for cooperation and merging of efforts, the Branch has made rosters of personnel from all three groups available to DHEW Regional Offices, promoted initial communication interchange between the PTA and Jaycees National Chairmen, and encouraged cooperative mental health association-Jaycee efforts. In consultations and presentations to advisory board groups, the Branch has been a merchant of communication in encouraging the development of unified citizen activity while retaining individuality of organizations involved.

The Citizen As Supporter and Policymaker

The citizen as a supporter and policymaker of voluntary health and social welfare agencies represents a major sector of the "helping" community. The contribution of the voluntary agencies to the advancement of community mental health programs is an area of needed emphasis. These agencies represent a vast system of services at the community level, including community planning, direct services, and family life education. Such programs have a direct bearing on extension and delivery of optimum mental health services to consumers. As a first step in initiation of formal liaison with these agencies, the Branch convened an Ad Hoc Committee of Voluntary Health and Social Welfare Organizations which brought together leaders of 14 major programs with related interests in mental health to

advise on program development. A strong recommendation of this Ad Hoc Committee was that similar meetings be held at the regional level throughout the country to bring together representatives of mental health and voluntary agencies toward the purposes of better understanding and sharing of goals in behalf of services to people.

The Citizen as a Direct Service Volunteer

Since the Institute itself does not operate a volunteer program (in contrast with the Veterans Administration, for example), the Branch role has been one of interpretation, information, and stimulation of interest in volunteering. The Branch has worked closely with the American Association of Volunteer Services Coordinators. This Association is composed of the personnel who plan, recruit, and coordinate volunteer services. For the most part, volunteer coordinators function in State mental hospitals; a few are employed in mental health centers and other community mental health programs.

Because few community mental health centers have a volunteer coordinator, the creation of this position has been encouraged. The Branch convened a representative committee of volunteer services coordinators to discuss the array of volunteer activities which could be made available to the centers.

Issues confronting the development of direct service volunteering are, in part, related to the historical background and growth of these services. For the most part, volunteer services have been extended to the "mentally ill," characterized by residence in a mental hospital or designated as having special needs as a patient group returning to the community from a period of mental hospitalization. There has been a minimum amount of volunteer services encouraged in community-based mental health programs. The emergence of the comprehensive community mental health center program calls for leadership in stimulating creative new uses of volunteers in all aspects of program. Retarding this development has been the over-protective attitude of many professionals in restricting the innovative contributions of volunteer services or in viewing volunteer services as a temporary stopgap in view of manpower shortages. Organizationally, there is also the problem that only a few States have a State-level coordinator of volunteer services.

The Citizen as a Board Member

With 34 States now having community mental health services legislation, the citizen has become vitally involved in planning and developing mental health programs through creation of State and local mental health boards. Many community mental health centers also have provided for advisory boards where the citizen can develop policy and insure that the operating program meets the needs for which it was originally designed.

The mere creation of citizen boards is insufficient without the availability of consultative, informational, and educational resources to assist them. State personnel are encouraged to develop regular methods of educating professional staff to work with advisory boards and to institute regular procedures for board workshops and conferences.

There are two audiences who must be reached in the communication network relating to citizen participation on boards. One audience consists of the board members themselves who

need encouragement and suggestions for making board membership truly constructive in the shaping of local programs. Another audience, equally important, comprises the professionals at State and local level who, in many instances, need assistance in perceiving the significant contributions to program growth and development which can be made by the citizen board member.

Citizen Participation Roundtables

The Branch has initiated a series of Roundtables for Central and Regional Office staff. This innovation brought the voices and experiences of local citizens to the Federal agency charged with responsibility for the mental health of the Nation.

The Roundtables were conceived as a vehicle for bringing to the attention of the NIMH staff a variety of models illustrating citizen involvement in mental health or mental health related activities. In addition to providing opportunity for citizens and selected professionals to present their programs and viewpoints, the Roundtables were structured to permit informal discussion between presentors and staff.

During the past year, there were nine Roundtables. Presentors came from urban inner city areas, rural portions of the country, and from the suburbs. Nine States (California, Colorado, Connecticut, Illinois, Michigan, New York, Ohio, Pennsylvania, and Vermont) were represented.

At the first Roundtable, "Temple University Center for Community Studies," a university-based team working in Philadelphia discussed the development of new kinds of training programs for nonprofessionals as well as illustrating their attempts to relate to the surrounding area. A resident presented his views of the program as it applied to citizens of a low income area.

A second Roundtable, "Mental Health Planning—Fact or Fiction," combined the professional research view with that of a citizen in reporting on a national study of mental health planning. Highlights were the reported deficiencies of planning, minimal citizen involvement in the process, and the strong point made for "resident citizen" involvement in planning.

The "Citizen Volunteer Counselors in the Denver County Court Probation Service" featured the different points of view of the Judge, the director of probation services, a volunteer, and a probationer (the consumer). The poignancy of personal anecdotal accounts of initial encounters between probationer and volunteer was balanced by data relating to potential agency and institutional change through volunteer experiences.

The fourth Roundtable, "Citizen Views of Mental Health Boards," brought together three citizens representing board roles in predominantly rural Vermont, a county mental health board operating under the New York State Community Mental Health Services Act, and an urban mental health center board in Chicago. The variety of views and experiences led to a better understanding of the contributions to be made by citizens, ranging from site location of the facility to interpreting needs and life styles of the residents.

"Citizen Participation in Evaluation" was the focus of another Roundtable. It was reported that under a program of the California Mental Health Association several hospitals use citizen visitation teams who do site visits four times a year to evaluate level of patient care, but not treatment. Another example is a commu-

nity mental health center that mailed questionnaires to residents of the catchment area in addition to observing citizens working closely with the program.

Perspectives on nonprofessional staff in rendering a broad array of social services to several communities in the Detroit area was the feature of the Roundtable, "Nonprofessional Worker: Experiences, Contributions, Viewpoints." Significant in this was the nonprofessional's ready identification of needs, his capacity to assist residents in organizing to present their needs to officials in an acceptable and persuasive manner, and his identification among his peers as a "helping" person still able to retain neighborhood acceptance while employed with an agency.

Other Roundtables were presented by the Lincoln Hospital Mental Health Center, the Fortune Society, and Recovery, Inc.

National Swap Shop

The Branch convened a national Swap Shop of 21 mental health centers on the topic of citizen participation. Participants came from all areas of the United States to exchange ideas and experiences on a wide range of citizen involvement. Representing the centers were directors, community organization staff, and mental health workers employed from the catchment area served. The Branch is also developing a similar Swap Shop for citizen representatives of these centers.

Religion and Mental Health in the Community

Liaison with the National Council of Churches' Inter-Faith Task Force on the role of the religious community in community mental health programs resulted in a national Task Force meeting. Active participation in this meeting of minority and poverty group representatives resulted in the creation of a new Steering Committee with both citizen and clergy members and with a sharper focus on community needs. Entrée to new citizen groups and access to consumers through a variety of clergymen and congregations provide opportunities for development of new citizen models of participation. The potential of the catchment area church as a resource for identification of resident citizen leaders and potential mental health workers remains virtually untapped across the country.

Citizen Role in Evaluation

The Branch is developing models utilizing the citizen in evaluation of mental health centers. Consultation is being given to a State association for mental health to develop an evaluation project embracing two catchment areas. A different model, originating from the Citizen Participation Department of a mental health center, is being initiated in a far western State. Other models will be encouraged in differing parts of the country to effect a variety of experiences pointing to the unique citizen role in evaluation.

Self-Help Organizations and Volunteer Participation in Social Welfare

ALFRED H. KATZ

I have defined self-help groups as "those which originate through the activities of parents and relatives seeking to bring about greater knowledge and better physical and socio-psychological treatment for their ill or handicapped child." This definition stresses the "self-organized" and "mutual aid" origin, as compared with the conventional establishment of social agencies by philanthropic interests.

On sheer magnitude alone, organizations formed in this fashion comprise an important segment of voluntary social welfare and health agencies. It would not be an exaggeration to estimate that more than a million individuals in the United States are involved in health and welfare through membership and volunteer service in self-help groups.

Somewhat in contrast to conventionally established agencies, self-help groups provide a wider variety of volunteer activities than participation in fund-raising campaigns alone. One finds the parents of children with cerebral palsy involved in the maintenance of activity centers for school-age youngsters. Parents of the mentally retarded staff recreation programs, sheltered workshops, and the like, in addition to participating in more common forms of volunteer service such as providing transportation.

In addition to the formal voluntary organizations that participate in fund drives, are affiliated with national organizations, and generally employ professional staff, a whole host of organizations has grown up formed by persons with a common problem and usually performing multiple services to their members on a local level, outside the framework of the usual community services.

We are thus concerned with a social phenomenon, a new kind of social agency that performs many social welfare planning and programing functions. To be complete, any analysis of voluntary agencies, voluntarism, and volunteers should take this large aggregate into account.

In Federal legislation, especially that dealing with the antipoverty programs, the importance of enlisting the participation of persons affected by a particular social problem, and presumed to have a stake in its solution, has been recognized. In recent years a number of programs have experimented with the enlistment of the poor through their neighborhood representatives in campaigns of social action.

These programs are a form of community activity with great inherent significance for their participants and for the health and welfare scene. One line of sociological analysis would hold that in seeking out face-to-face interaction with peers and other individuals with similar problems, many persons who participate are counteracting anomic and isolation tendencies of society. Such activity may have become necessary to compensate for the decline of the extended family in contemporary life. The small nuclear family requires a supplement since it can no longer sustain the total burden of socialization and support hitherto carried by the extended family.

Condensed with permission from *Social Work*, 15(1):51–60, 1970.

Structural Features of Self-Help Groups

Eight features that characterize the self-help group and distinguish it from other types of social agencies can be isolated: Self-help organizations share the properties of small groups. They are problem centered, organized with reference to a specific problem or problems. Members tend to be peers. They hold common goals. Action is group action. Helping others is an expressed norm of the group. The role of the "professional" is not clear-cut, if it exists at all, in the self-help group. Power and leadership are on a peer or horizontal basis.

Functional Attributes of Self-Help Groups

From these defining structural characteristics flow more general functional attributes of self-help groups, which again serve to differentiate them from conventional social agencies:

Communication is horizontal rather than vertical.

Personal involvement becomes a requirement in all self-help groups. In contrast to most social agencies and many organizations, membership does not include members who are passive recipients or financial supporters. Each member is expected to involve himself in and to work for the good of the group to his best capacity at the time. There are indications that a sensitivity develops to the capacity of fellow members. In Synanon, for example, it is understood when a member is not ready to perform a certain action; thus, sympathy, leniency, and tolerance may be extended. Yet, at the same time, the converse is true, and group members can be more stringent and even punitive with a laggard member than would be possible with a nonmember. Motivation to join is partly individual and partly social. While the primary motivation may be self-improvement, group goals and group welfare come first and self-improvement comes as a by-product of working for the group welfare.

The individual member is held *responsible for his own actions.* Such a level of personal responsibility is not generally required of other volunteers or members of social welfare organizations.

Groups are *action oriented,* their philosophy being that members learn by doing and are changed by doing. A result is that the groups afford an opportunity for enhancing members' self-esteem by successful or useful endeavors.

Processes of Self-Help Group Influence

A series of processes occur that may be applied in the analysis of self-help group phenomena: Peer or primary group reference identification; learning through action—attitude and knowledge change through experience and action; facilitation of communication because members are peers; enhanced opportunities for socialization; breaking down of individual psychological defenses through group action, open discussion, and confrontation; emotional and social support of members by one another, reduction of social distance among them as compared with the distance maintained from agency staff or professionals; provision of an acceptable status system within which the member can achieve his place—status is defined according to group goals and needs, the individual's status can be clearly defined; simulation of or proximity to conditions of the outside world in the groups, as compared with the institutional setting or professional client-practitioner relationship; the "helper" principle which holds that in helping others, group members achieve therapeutic goals for themselves.

Dimensions of Volunteer Activity in Self-Help Groups

The phases through which self-help groups pass can be outlined as follows:

Origin—Two or more persons are motivated to perform a remedial action regarding a common problem. Such individuals may advertise in the public press, attempting to reach others who share the problem. A public meeting may be organized. All work is carried out by the volunteers who initiate the project.

Informal organizational stage—The movement begins to spread through friends and acquaintances; face-to-face group contacts occur, public meetings are held, and volunteers engage in enlarging the circle of participants. They develop rudimentary program ideas and community contacts and begin to cultivate a few prominent or "strategic" people, professionals or influential laymen.

Emergence of leadership—Each group presents the opportunity for strong leadership to emerge in the person of one individual or a group of associates. These leaders assume the most important tasks. Part of their function is their ability to involve other volunteers in routine tasks; innovative activities become the prerogative of the leaders. Eventually, certain functions become identified with certain persons within and outside the leadership group.

Beginnings of formal organization—As a definite leadership core emerges, the group enters the stage of more formal organization. An organizational structure is developed and codified in rules or bylaws. Structural changes become necessary by reason of the increasing volume and complexity of the functions undertaken by the group. There are increases in program activities, a more ramified administrative structure is needed, and an expansion of contacts with community agencies, other groups, and professional workers occurs.

Beginnings of professionalization—The leadership group may find it necessary to give up organizational functions to paid staff. As professional activities are undertaken, professionally qualified staff may be added. But despite professionalization, volunteer functions remain broader, more intensive, and more varied than in the more conventional private social agency.

Activities reported for volunteers in conventional agencies can be classed under the following:

Fund-raising—usually under professional direction.

Board service (policy-making)—restricted to relatively few.

Patient service, usually adjunctive to professionals.

Public relations, often under professional direction.

In contrast, volunteer activities found among self-help groups include:

Fund-raising—frequently without professional direction.

Policy- and program-making—usually more broadly spread than in the conventional agencies.

Social action activities—lobbying, pressure groups, etc.

Public relations, including widespread public interpretation to a variety of audiences.

Patient service, often more significant and less adjunctive "professional-helper" roles, e.g., as teachers, social-recreation leaders, vocational counselors; participation in group education; discussion of adjustment problems such as finding a job, preparing a résumé; discussion of relationship, e.g., with relatives; discussion of social actions the group can

take; provision of transportation, baby-sitting, and other services.

Characteristics of Volunteers

Volunteers are drawn primarily from the middle and upper classes. Persons having sufficient wealth or for whom volunteering is a path to upward social status predominate. For those persons affected by a problem who join with others for mutual aid, the careerist motive has lesser importance. Social class does not determine participation. Such conditions as mental retardation, cerebral palsy, and alcoholism cut across class, socioeconomic, and occupational lines. In the purest form of self-help group, a wide variation in educational background and occupation has been observed.

Motivation for volunteer participation is a complex phenomenon: ideological, social, and personal.

One conclusion that can be drawn from studies of volunteer motivation is that a compelling motive is found in seeking solutions to personal problems. However, a displacement of goals can occur. The volunteer originally seeking personal help is able to pass to a stage in which he obtains satisfaction through helping others. This dynamic is not usually reported from studies of the middle- and upper-class volunteer in conventional agencies, but it may be observed in self-help organizations and it constitutes a powerful social force.

Self-help organizations are here to stay and will continue to provide extensive opportunities for volunteer service. Social scientists should utilize the rich laboratory setting that these organizations provide for the study of organizational behavior and small social systems and for the analysis of pertinent and inventive volunteer participation.

An annotated bibliography, "Self-Help and Rehabilitation," dealing with social science literature relevant to self-help groups and physical and mental rehabilitation is available from Dr. Katz.

Guidelines for Marital Sex: An Analysis of Fifteen Popular Marriage Manuals

Dennis Brissett and Lionel S. Lewis

In an earlier paper we showed how the precepts of certain avocational counselors have defined marital sexual activity as work. ("Avocational counselors" refers to those persons who provide the American public with advice on play and leisure activities.) A division of labor in marriage has been documented by sociologists. That there might be a division of labor in marital sexual activity itself has long been recognized. Sociologists have offered little evidence bearing on the character of this division of labor. What is considered here is the manner in which this division of labor is portrayed by the avocational counselors of marital sex.

The doctrines of the avocational counselors of sexual activity were ascertained by an analysis of 15 marriage manuals. The 15 volumes ranged from 14-page pamphlets to full-sized, hard-bound books. Each manual was read by both of us and principal themes were recorded. Only material about whose meaning we both agreed was utilized in drawing conclusions about the themes in a book.

The Sexual Role of the Male

That the role of the male in sex is portrayed as significant and complex is established by the fact that between three and four times as many prescriptions for behavior are directed to the male as to the female. This proliferation of prescriptions can be analyzed in terms of the responsibilities of the man in sexual conduct and the control and restraint the man is supposed to practice in his sexual excounters.

The male is ascribed the overall responsibility for achieving satisfactory sexual relations. This responsibility is all-inclusive. It endures as long as the marriage itself. Neither does it diminish over the phases of the sexual act. During intercourse itself, the male is the responsible lover. He is reminded that he must be the leader and must perform a set of specific duties in order that the love-making sustain itself.

The duties for which the man is held responsible in sex play range from a diffuse set of obligations to highly specific chores. The former concerns his being properly educated and properly educating his partner. The latter in part concerns the application of the special equipment of sex. Here the male is envisaged as an administrator of the paraphernalia used in facilitating sexual relations. Notwithstanding certain methods of which the male is physiologically incapable, it is he who must apply the special techniques used to make the experience more pleasurable. Thus, he is given a choice of using a local anesthetic to help him or a condom which can also be utilized to increase the ability "to prolong coitus." If his penis seems to be too long a ring of sponge rubber should be slipped over it to control depth of penetration. If his penis appears to be too small, he is advised that its size can be increased by pressure on the dorsal vein.

The sexual responsibilities of the male are elaborated to involve a great deal of emotional constraint and physical control. Constraint is dealt with in terms of the male's pacing

Condensed with permission from the *Family Coordinator*, 19(1):41–48, 1970.

himself either to prolong some phase or the whole of the sexual act, or to facilitate simultaneous orgasm of the partners.

In the course of prolonging sexual activity, the male is called upon to control his own sexual impulses. In fact, controlling his natural physiological reactions seems, at times, to be his most important duty. Physical control is the most pervasive idea found in the 15 books. The idea of control, moreover, is presented in deceivingly simple terms.

There are a variety of ways in which males are advised to achieve control. When "things get out of hand," it may be necessary for the man to continually interrupt his program of activity. Those men who might find such interruptions annoying are given the alternative of practicing seminal retention which involves training oneself to control certain obscure muscles.

The role of the male in sexual relations, then, is depicted as being based upon an instrumental responsibility, this responsibility being qualified by constraint and control. It is made out to be complex and arduous. The male is saddled with the fashioning of the form and content of sexual relations. He is the person who establishes and maintains the direction and intensity of the sexual conduct. That this is an intricate and taxing activity is underscored by all the authors. In fact, the effort required is not common, everyday effort. Even when the efforts are not special, they often seem more appropriate to an acrobat than to a lover. Sometimes the man is advised to stand, support himself on one arm, snap "the penis two or three times during slow stroke" all the while keeping "one finger busy at the clitoris throughout the early stages . . . and add [ing] very active breast or buttock stimulation with the other hand."

The effort is deemed worthwhile and, indeed, mandatory. For if the male does not take the upper hand in sexual relations, he is threatened with dire consequences. A sexually mishandled woman can suffer "nervous strain," "irritation," "headaches, . . . sleeplessness, and other symptoms of maladjustment."

The male is directed to keep the happiness of his partner in the forefront of his mind. He must often subvert his own pleasure to the adequate performance of his role. Often techniques which are prescribed to promote sexual satisfaction actually seem less than pleasurable to the male.

The Sexual Role of the Female

The female sexual role appears to be relatively simple. The basic theme has to do with her ability to bring her sex life under conscious control. This consciousness involves a degree of responsibility, but the responsibility is different from the male's. It consists of ensuring that her partner will be able to perform his role adequately. The responsible female is one who passively goes along with her partner's wishes and supports his activity.

The responsibility to serve her partner's needs leads to the establishment of other role requirements for the woman. Again, these duties are involved with ensuring her partner's sexual success. For instance, the female at certain times may be called upon directly to guide her partner's physical movements. In fact, the responsible female can even help her partner pace himself.

Successful sexual activity is contingent on the ability of the female to communicate to her partner all pertinent sexual information about herself. In this manner, his performance will be grounded in sexual reality.

As well as furnishing the requisite knowledge, it is the woman's duty to learn certain sexual techniques, so that her partner will be better able to bring her sexual satisfaction. For the most part, these techniques involve learning muscular control and coordination; and the female is instructed in this fine art. She must, in a word, master the not so spontaneous activity of love play. Like the act of being consistently available, the process of learning how to love may be less than enjoyable. That the female should thoroughly learn her role and the skills appropriate to it is a point made in all of the books. Like her partner, she must prove efficient in her performance.

Rational Reciprocity

Given the reality of these two sexual roles, the nature of the interaction becomes important. Without question, the nature of sexual interaction as described by the authors of these books can be characterized as "rational reciprocity."

The idea is that the path to sexual harmony requires the constant rational application of sexual knowledge and experience to the discourse of sex. Sexual activity becomes a conversation. Like all communication, this process involves role taking. Each partner is cautioned to place himself in the role of the other if the act is to be satisfactory. Furthermore, the role taking should be the basis for "other-directed tolerance." In this way efficient sexual activity may be more reasonably ensured. And if it is efficient, the implication is that it is satisfying.

The description of marital sex provided by manuals has practical implications for the family life practitioner. The wide circulation of these manuals is an indication of their importance as pedagogical tools. It would seem mandatory that the professional familiarize himself with the assumptions and ideals of the manuals since many clients may be guiding their behavior in line with these assumptions and ideals. Rather than assuming that a "good marriage manual" will help resolve sexual problems, the family life practitioner may consider their harmful effects. It is our contention that the manuals are espousing an ideal of sexual activity that is difficult to attain, particularly for the male. An attempt to measure up to the guidelines may be a source of certain sexual difficulties in marriage.

We also are dubious about the nature of sexual activity depicted as ideal. To achieve a highly organized, extremely rational kind of sexual life does not appear to be necessarily idyllic. It seems questionable that people continually should have to constrain, control, and suppress their emotions, impulses, and passions, in order to achieve a satisfactory sex life; at the least, it seems unfortunate.

The Unrecognized Professional

LAURIE LOMBA

The community mental health secretary is a specialist. She must be more than a secretary; she must be a dedicated mental health worker. She is a window through which the community sees the mental health professionals and through which, if they will look, the professionals can see into the community. She provides the help-seekers' introduction to the concept of "community mental health."

The community mental health secretary must know the community she serves as part of the mental health team. She must keep her finger on the pulse of the community; she must be aware of all legislation affecting it; above all she must develop an informed mind that places her on the team of professionals serving the community. Her understanding the community and its social influences on those she serves will add greatly to her value to the helping professionals and to the community.

There are as many roles for the secretary in community mental health as there are clinicians and administrators to define them. Once she chooses the field of community mental health, the secretary's job ceases to be a 40-hour-a-week one. She may find herself in overalls working side by side with the people in the community on a special project, or attending seminars, official functions, or even protest rallies.

The role the mental health secretary plays will be dictated by the demands of the center in which she serves and the community in which the center is located. The size of the staff will be a determining factor. In a small center, the secretary may wear many hats: She may function as receptionist, interviewer, file clerk, coffee-maker, switchboard operator, statistician, cartographer, answering service, public relations person, finder of missing persons (patients and staff), typist, confidante, painter and carpenter, soother, and hell-raiser. She can count on two things—being overworked and underpaid. In a large operation, she may work within a particular department or division. Chances are that although the center may grow, it will begin in a small division within the department of psychiatry of a general or university hospital.

It is beneficial if the secretary joins the staff at the beginning of the program. She will then be "in" on the growing pains and will herself grow with the program. She can be a vital part of the program and should be an important member of the team. This means that other staff must permit her to use her professional and personal skills and to accept the responsibilities she is capable of assuming.

If the secretary is to be effective in dealing with, for example, a culturally, socially, and economically deprived urban population, she must have a degree of empathy that nothing short of personal involvement can provide. In cases in which she is "on the team," she must have the understanding of a wife, loyalty of a dog, and optimism of a ten-year-old. These qualities she must display primarily toward the professionals, but she must also use them to help patients. At the start, a knowledge of human relations will suffice. On this the professional community mental health secretary

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can build as she becomes more knowledgeable concerning other staff, the patients with whom she has frequent contact, her co-workers, and the area her center serves. She must never assume the therapeutic mantle of the helping professional. Her role is that of "stop-gap" until a patient can be seen by the appropriate person.

The other side of the coin is presented by those who find the presence of a capable, well-informed, articulate secretary threatening. Such people can harm the program in many ways. The problem that concerns us here is their inhibiting the secretary to the point where her experience and training are wasted. She is then faced with the alternative of staying on as a stenographer or leaving for a position in which she can utilize her professional skills.

We are at a professional crossroad. A step forward is being taken by the Community Mental Health Associates. This fledgling organization has embarked on a pilot program to provide specialized training for its members. The organization is proceeding with a program consisting of visits to community mental health centers in the Baltimore-Washington-Philadelphia area. Once funding is available, a three-year training program will be launched. The culmination will be a manual for the community mental health secretary. The program will provide the nucleus of a nationwide corps of well-trained clerical personnel to staff not just community mental health centers, but all community-oriented facilities devoted to the well-being of the public.

One worthwhile outcome of the Association has been an increased awareness on the part of its members of many relevant agencies. Participants come from health and welfare agencies; Federal agencies concerned with mental health; city and State mental health facilities; private, State, and university hospitals; and a variety of mental health organizations. An exchange of information and services has taken place among the participants that had been missing at higher levels of communication. A small directory prepared by one member serves all the agencies represented.

The community mental health secretary can assist the clinical professionals by taking over details with which they are burdened and which she can handle. Thus, by utilizing one of their most valuable yet most unrecognized assets, the clinical professionals can have an added measure of time to devote to their work in the community. The competent mental health secretary can indeed be an important member of the community mental health team.

Money Management and Mental Health

Helen C. Potter and George T. Stanton

The money worries of the seriously disturbed may stand in the way of their recovery. The bills accumulated when emotions dictate endless spending are not eliminated by psychotherapy. Neither does the individual learn from therapy the techniques to manage his money and to carry out a plan for paying his bills.

Money therapy can be a valuable complement to psychotherapy, as financial worries frequently precipitate the call for professional help. Money therapy can be a means of winning the confidence and cooperation of the patient and maintaining it during a difficult initial period of psychiatric therapy.

Money therapy is a form of situational therapy that can often help the emotionally disturbed even when it cannot be accompanied by psychotherapy. Its limited directive measures are aimed at reducing money worries.

Money Problems of Patients

Everyone could use help with personal finance, but psychiatric patients have a greater need for such help. Mounting debts may become a problem for them, for their need for spending may not diminish as purchases are made. They may be trying to buy something that is not for sale—love, self-esteem, or a remedy for inferiority feelings, self-hate, or depression. The greater the intensity of inner anxieties, the greater their desire to spend. Their debts will likely go higher and higher if credit is available, for this spending is neither contained by income, related to financial resources, nor geared to physical need.

Persons suffering from neurosis may let bills pile up because of difficulties in attending to details. Even the task of writing and mailing a check may loom before them like a mountain. They forget their bills because they want to obliterate criticism, even this reminder of mismanaged money. With a growing debt their freedom of choice dwindles as more income is eaten up by creditors. With so many compulsions restricting their freedom, this added curtailment is especially upsetting.

The frustration of nothing to show for the money is another problem. Some patients are caught in the grip of indecision when trying to make a purchase and they finally buy, to get the ordeal over. The fear of making a mistake in market selection that would jeopardize their image of self may cause this indecision.

Money problems may stem from grandiose, theoretical plans that satisfy their egos but are unrelated to their income, needs, and outstanding bills. Patients also nullify some good plans by not allowing them to have the flexibility needed, due to fear of jeopardizing their self-image of perfection. Their financial difficulties may be caused by a cavalier attitude toward employment. In certain types of emotional disturbances the individual is likely to quit his job impulsively without giving any thought to the economic security sacrificed. A change in work will, he thinks, break the hold that depression has on him but he fails to realize that the cause of his depression is within himself. Or, the individual gives up his job because he

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thinks his boss or associates treat him unfairly. Actually, the malice he sees in others is a reflection of his own self-hate. Unemployment adds financial worries to those already there.

Psychiatric care may aggravate the financial problems of patients because of the cost involved. The interaction of the very small supply of psychiatrists and supporting staffs and the very large demand for their services cause the price to rise in accordance with the economic law of supply and demand. The exclusion of mental illness from the benefits of many medical insurance plans increases its financial burden.

Financial problems may be encountered long after recovery because of low remuneration for work. Many employers who employ the physically handicapped are unwilling to hire someone "with a history of mental illness."

Money management therapy could help the individual equip himself with the knowledge and skill to ward off financial difficulties and cope more effectively with those he must encounter.

Implementing Money Management Therapy

Personnel for money management therapy may include persons with various backgrounds if adequate preservice and inservice training is given. Psychiatrists should be mindful of this therapy, observant of their patients' responses to it, and resourceful in making use of it.

The first job of the money therapist is to see if he can give the patient some immediate relief from financial worries by altering environmental conditions. He should study pertinent contracts and contact creditors to arrange for a delay or reduction in payments and an extension of the duration of the loans without fines, harassment by collectors, or garnishment. He may solicit relatives for contributions to be used for loan installments past due and for three to six months of future installment payments. If a contract appears fraudulent, he should contact the State Attorney's office, Bureau of Frauds, or a legal aid society. If the patient's problem is fear that illness will exhaust his resources, the therapist may get the patient moved to a cheaper room, a different hospital, or from private to clinical care. If the patient is worried about being unable to manage his affairs, the therapist might obtain a trust officer, an attorney, or a qualified relative or friend to act for him.

Group therapy as well as individual help is desirable. The patient's financial problems seem less overwhelming when he sees that others have similar ones. As group therapy costs less than individual therapy, the patient can afford a longer period of such therapy. Effectiveness is enhanced by the use of simple situations based on the immediate needs of patients, familiar examples taken from real life, active participation by members, frequent exercises with the sequential steps readily apparent, concrete and easily obtainable goals, and a calm, encouraging atmosphere. Short movies or film strips, if well selected, can add interest and motivation as well as instruct.

The therapist has to keep in mind the difference between the healthy person and the emotionally disturbed in his attitude toward satisfaction of wants. The former realizes that his endless wants cannot all be satisfied because of the limited means available. The emotionally disturbed individual tends to look on all wants as essential, as each represents a lifeline to goals that insecurity makes imperative. With therapy, this individual can

learn to recognize the limits that productivity places on his spending and can even begin to experience pleasure from making choices.

The suggestions that follow may serve to motivate others to develop techniques of money therapy. Each unit represents a subject-matter division, not a unit of time. A part of a unit might be introduced into a session that is not primarily for money management therapy. Some topics might be considered in sessions where group members serve as the leader. A Recovery group might work on improving money management and call in specialists.

Suggestions for Group Therapy in Money Management

Unit 1—What is your problem?
- Show movie to which patients can relate.
- Let discussion of film motivate group to air their financial problems.
- Open question-and-answer period.
- Consider the nature of fixed commitments and how they reduce income for current use.

Unit 2—What do you want for your money?
- Show by graphs the differences in expenditures of families with smaller incomes.
- Group suggests reasons for these differences.
- Group considers the relation of values to goals.
- Other reasons: need related to age, stage in life cycle, family size, stock of durable goods, future needs and relative importance given to them; individuality, knowledge, and consumer ignorance.

Unit 3—Getting more for your money.
- Each member tells about a purchase he regretted.
- Group compiles list of why unwanted goods are purchased.
- How to avoid fraud and deception.
- Where to go for information.
- How to recognize and control compulsive and impulsive buying.

Unit 4—Planning use of resources.
- List what you want to purchase next week.
- Use catalogs and advertisements to decide on each contemplated purchase.
- Total prices and compare with anticipated money for spending next week.
- Rank wants and delete least important ones until total prices balance with anticipated income.
- Consider the need of flexibility. Discuss means of control.

Unit 5—The art of shopping.
- Show candid camera shots of shoppers.
- What you should and should not do as a shopper.
- What is the role of shopper and clerk?
- Each member reads the advertisements, labels, and other material, reports information useful to shopper, important information omitted, whether ad appeals to reason or emotion.
- Danger of advertising persuasion and how to avoid it.
- Why shopping may be feared and how this fear may be eliminated.

Unit 6—Stretching your money.
- Discuss how to stretch money by simple living and daring to be different.
- Group compiles a list of what they waste —water, light, Kleenex, paper towels, etc., and their money leaks on cokes, cigarettes, cocktails, etc.
- Group discusses reasons for the waste and leaks.
- When is a "bargain" not a bargain?
- Why does a gambler always lose in the long run?

Unit 7—Using credit.
- Show film.
- Discuss why, when, and how to use credit and how to determine credit limit.
- Costs of credit.
- Eliminating the cost of credit by saving.
- What to do when overextended—is bankruptcy the answer?
- What to do when the car breaks down and you have reached your credit limit.
- Planning for major items.
- Examining the installment contract.

Unit 8—Saving.
- Why is an emergency fund needed?
- How large a fund do you need?
- How can you force yourself to save?
- Types of savings compared with regard to safety, interest, and liquidity.
- When and how to invest.
- Trading on a security or commodity market is serious business.

Unit 9—Insurance.
- Show movie.
- What is insurance?

Property, health, life, and annuity insurance compared.
Means of reducing insurance costs.
How much insurance do you need and can you afford?
A life insurance contract is examined and explained.
Benefits under social security are discussed.

Unit 10—Choose your topic.
Suggested topics: Your Taxes; Preparing Tax Returns; Finding a Good Car You Can Afford; Do it Yourself to Save and Have Fun; Indirect Costs of Buying a Home.

Will Money Therapy Work?

This question poses two others: Will the problems of patients prevent them from learning to manage money? Can money therapy fit into a psychiatric program? Educators who worked with the emotionally disturbed have found that they can learn if the material is simple, concrete, and related to immediate needs. Money therapy is consistent with the greater use of limited directive measures aimed to alleviate symptoms, and therapeutic programs adapted to the patient's needs and capacity which integrate many types of resources to achieve maximum effectiveness.

A list of pamphlets and films suitable for use in money management therapy is available from the authors on request.

Social Advocacy: A New Dimension in Social Work

MARY J. MCCORMICK

The dimensions of social work are difficult to identify. Perhaps this is one reason why the present commitment to *advocacy* (in contrast to *reform* in the early 1900's and *therapy* in recent years) gives rise to concern, and even consternation, among those for whom reason and discipline, rather than feeling and emotion, direct professional activity. The apparent abandonment of familiar structure and methodology appears to be a potentially destructive factor in social work at the threshold of the 1970's.

There is another vantage point from which the situation can be viewed—social change. Within this framework, the new and the untried can be appraised in the light of the circumstances that spark the desire for change and then in the thought and action of those who assume responsibility for making that desire a reality. In this continuum of cause and effect, with its judgment on what should be as well as what is, the new and the old assume complementary roles and together offer a rationale for what is to follow.

If the advocacy concept follows this pattern and retains the strengths of the past while shaping the innovations of the present, social work should not be in jeopardy. If acceptance of the new diminishes the import of the old, the fears of the skeptics could be realized.

In the face of this contingency, it seems worthwhile to explore the concept of advocacy within the total context of the helping process and to evaluate it against man's desire for, and implementation of, planned change. Both the desire and the fulfillment are reflected in the objectives of social work as these have evolved over the years—from the reform of the pioneers, with their reliance on social conscience, to the therapy of the clinicians and their focus on the individual unconscious. Against this background, advocacy, with its unreserved commitment to the "plight of the disadvantaged," stands out in bold relief; it adds a new dimension, that of breadth, to the objectives of the social work of the future.

Perhaps because this dimension is essentially political-social in nature, it seems more akin to revolution than to evolution; hence the fears that it engenders. The anxiety reaction is likely to persist, in varying degrees, until such time as advocacy in the abstract (in its conceptual meaning) is internalized, that is, until it becomes an integral part of the structure and function of social work and of the basic convictions of social workers—administrators, educators, and practitioners alike. Only then will advocacy, in the concrete, be recognized as an acceptable, professional objective, grounded in a social structure that makes possible the legitimation of political-social action. It is in this process of legitimation, when personal ideas and ideals become absorbed into the social system (become institutionalized), that advocacy—as idea and ideal—will find justification and support within the structure of social work at the professional level.

The concept of advocacy has been associated with the defense or promotion of a cause and, more specifically, with pleading the cause of another. In the first instance, the activities are

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political-social; in the second, they are personal-social. In the political context, the objective is to bring active support to ideas and programs that will benefit society as a whole, as well as particular segments of it. In the second, the focus is on the individual in his relations with other individuals and institutions.

Advocacy is an instrument of social action. As such, it brings the dimension of breadth to plans and programs directed toward change and supplies the vitality and dedication that are important assets.

It seems reasonable to assume that disquietude prevails, to greater or lesser degree, both among the traditionalists, who are committed to the structure (of social work) that has been developed over the years, and among the more liberal-minded, who are disillusioned by that structure. Followers of both persuasions will likely agree that, in an era of rapid change, the real test of a profession is its ability to meet constructively the demands of that change. However, they will disagree about the quality and quantity, the character and extent of change, and about the controls to which it could, or should, be subjected. Must change be supported unconditionally? Should advocacy as an instrument be left unhampered, or should guidelines be set and limits imposed?

Answers to these questions are difficult. They revolve around the importance attached to such factors as ethical codes, objective judgments, decision making based on scientific knowledge, skill in problem solving, and the proper use of authority; they are associated with the criteria of a profession. This means that the professional person, as he contemplates the political aspects of advocacy, must make the comparison, and mark the contrast, between the *professional* approach and the *political* approach.

In pursuing its objectives, political-social action admits and often relies on practices that have been anathema to the professions. For example, such action not only approves but encourages *manipulation*. This manipulation permits and sometimes makes mandatory a highly partisan representation of interests that rules out opposing positions per se. Its thrust depends on total commitments to a cause.

This reference to the characteristics of advocacy in its political-social context is not intended as criticism. The intent is to examine what seems to be its "core" technique: manipulation as it relates to the social action that is social work and in turn influences the social-worker-in-action.

Social work, as it functions within the professional frame of reference does have a common denominator, namely, a Code of Ethics. The preamble to that code emphasizes "service for the welfare of mankind"; it identifies practice as a "public trust" that requires . . . integrity, compassion, belief in the dignity and worth of human beings, and a dedication to truth." The code spells out these responsibilities as they encompass the social worker's "relationships with those he serves, with his colleagues, with his employing agency, with other professions, and with the community." The wording is interesting. It can be interpreted *either* as giving priority to those who are served *or* as attaching equal importance to colleagues, agencies, and communities. If this latter interpretation is accepted, then the scope of responsibility is broadened and the principles of the code apply to each of the designated groups.

This either-or-factor is, perhaps, the crux of the potential conflict that exists between political-social action and professional action.

The dilemma thus created is recognized in the report of the National Association of Social Workers Ad Hoc Committee on Advocacy, which mentions the "possibility that in promoting his clients' interests the social worker may be injuring other aggrieved persons with an equally just claim." In this situation "professional norms would appear to dictate" that such claims not be pressed "in a partisan manner"; the professional person should "seek to weigh the relative urgency" of such claims. The operative word is "relative"; diverse issues must be balanced within a total situation, and their relationship to each other must be weighed in that balance.

This absence of specificity means that the answers to the questions surrounding partisanship, and therefore manipulation, can be found only in the principle of personal responsibility.

Advocacy and the Helping Process

Within the framework of the helping professions, the concept of advocacy is generally associated with the law and, therefore, with the "social relationship." As an instrument of this system, it is the duty of the advocate (lawyer) to represent his client within the bounds of the law. Failure to meet these obligations carries definite sanction. It leads to the enforcement—by the profession itself, by agencies of government, or both—of disciplinary measures that are supported by the rule of law and by a society that respects this rule.

The duty of the advocate (the social worker) extends beyond representation of a client within established boundaries; it calls for involvement with a client in a multifaceted situation that is sociopsychological in character and therefore highly complex. The goal may be social betterment or personal development. Since advocacy is a form of interference, it finds its place among the responsibilities of a profession committed to the kind of involvement that sets in motion the helping process and directs it toward service for the welfare of mankind.

At the performance level, this goal is defined by methods that social work claims as its own: casework, group work, and community organization. At this level methods and process are consolidated in the professional relationship. Once this is established the social worker is able to participate constructively in the life experiences of other persons, as individuals or as members of a community. In the course of his participation, he comes face to face with the challenge of advocacy in its *role* and its *use*. In this confrontation, the social-worker-in-action must make his own judgment about the role of advocacy in the helping process and the validity of its use in the service of human beings.

In the resulting activity, social work may speak alone as the responsible advocate, or it may join forces with other professions and groups.

There are two choices. One leads to diminished responsibility by withdrawal into specialized areas of practice or restricted areas of a community. The other leads to positive action by bringing services to people, whoever and wherever they are.

If social work follows the first course, its future can be jeopardized by activities that are out of touch with a society in which change is the order of the day. Such a course will bring social workers face to face with additional problems of decision making. The goals may require practitioners, administrators, and educators to engage in expression and action that are controversial.

Commitment like this is serious, de-

manding, and often frustrating. There must be an additional dimension. Currently, that dimension seems to be *advocacy,* both as concept and as instrument. Conceptually, such a dimension represents the ideas and ideals of a democratic social order and of social work as a profession; instrumentally, it exerts forceful influence on what happens, both in the order and in the profession.

If advocacy is accepted as a plus value in the helping process, then it should be distinguished from the more familiar political and legal forms. This distinction is to be found in the social character of the advocacy that focuses on the whole person within the whole situation and finds its orientation in knowledge about the complexities of human nature and the pressures to which human beings are subjected. In the attempts to remove or alleviate these pressures, social advocacy as an instrument of social work is identifiable by the objective consideration that it gives to means and to ends, to the ways in which its goals are approached, as well as to the goals themselves. It seems reasonable to expect that this consideration will extend to the formal structure of social work as well as to its professional practices. The principles and values of social work as it has evolved over the years will be recognized and respected by those who are committed to advocacy as a challenging technique and a new dimension.

This concurrence with certain aspects of established structure and principles does not preclude rational attempts to change the structure and reassess the principles. Responsibility for implementing such examination and change rests with equal sanction on those who maintain a loyalty to the old and those who are committed to the new. Each must be willing to learn from the other and to act in accordance with that learning. This kind of reconciliation is challenging insofar as neither party can afford to violate its convictions or relinquish its identity.

The balance is not easy to achieve, but social work is not inexperienced in such an achievement. It seems that the issue can be resolved only when social workers, irrespective of individual differences, are capable of thinking and acting with the integrity, competence, and dedication to trust that symbolize the idea and the ideal of "service for the welfare of mankind."

Behavioral Science for Elementary School Pupils

BARBARA ELLIS LONG

We know that we are not preventing emotional disturbance; we know that the clinic population is growing out of bounds and that our repair institutions cannot keep up with the demand.

The question arises: "Why not prevent as well as mend?" The next question is "How?" and the next "Why not teach children something about themselves in school and make sure that the subject matter is tied closely to real life?" Wouldn't this be mental health education of the most potent kind?

To test these ideas, I began the development of a curriculum in the behavioral sciences at the Webster College Experimental School in St. Louis. Weekly sessions were arranged with 12 sixth-grade children, six boys and six girls. Six boys were added; three were fifth-graders and three were fourth-graders.

The children were from the middle and upper socioeconomic levels. It remains for other studies to establish whether the program or an adaptation would be suitable in other places with other children. Intelligence quotients ranged from 105 to 155. The general mental health of the children showed a wide range. One child literally bounced with the joy of life; another was seeing a psychiatrist at regular intervals.

After the first few weeks it was found that the children responded with great interest to a plan that allowed them to try out experiments or games on various topics from the field of psychology.

The approach was nondirective, except that the experiment or game was planned and introduced by the teacher. After the experiment, the children were asked for their conclusions and indirectly helped to find some answers. Emphasis was placed on practical applications and the children's real life experience of the phenomena.

The first sessions that seemed to be successful were those in which the children were given something to do. The lessons were based on laboratory experiments, mainly on the senses, borrowed from introductory psychology. Small cards with printed directions for the experiments were arranged around the room along with the equipment. For each experiment there were two sets of cards. One set gave directions; the other, turned face down till after the experiment, listed questions about the results.

After the experimental psychology unit, I provided experiences with topics that are standard in any introductory course—perception, learning, emotions, child development, and personality.

An unexpected bonus occurred when one boy refused to accept the fact that the retinal image is upside down. His question seemed to provide an avenue for the class to enjoy a vicarious battle with authority. I encouraged the boy to continue his attempts to disprove the thesis. He worked sporadically all year, continuing his challenge, if only as a point of honor. The challenge taught all a new way to resist or to battle authority—by scientific proof.

There were other incidents that taught me to listen closely, watch care-

Condensed with permission from the *Elementary School Journal*, 70(5):253–260, 1970.

fully, allow the children to comment freely, and discuss with them their ideas. Role-playing was useful. Simulation games were excellent for demonstrating a concept and starting a discussion.

I slowly turned over more of the direction of study to the children. They chose what they wanted to study and even designed the experiments they wanted to try. The children spent most of the second semester on social psychology and were particularly interested in engineering group behavior. They started fads, tried rumormongering, and will probably never forget how easy it is to be taken in by group pressures.

Their comments during the lessons were amazing. The wise and intuitive manner in which they approached the study of human behavior made me wonder how much we have lost by our educational methods. We forget that children are learning about behavior every day.

The first question posed in this study seemed reasonably well answered. Children in the upper elementary-school grades seem able to learn the content of the behavioral sciences.

The goal of prevention is still open. It seems reasonable that if one learns more about people and how they behave, one will have additional coping skills. General observations of the class indicated that the children seemed to grow in their ability to deal with problems and conflicts. The children did develop well-integrated skills in speculating on their own behavior and that of others.

The incidental goal of increasing interest in the behavioral sciences at an earlier age appeared to be quite possible.

One difficulty in this approach to mental health education will be its practical application in schools even after all our studies are validated and we are sure that we are on the right track. Because of the localized nature of most educational systems, there will be the problem of convincing administrations to set up such a program. The certification laws for teachers will also pose a problem.

The development of community mental health centers may offer a solution to the problem of funding and implementation. We seem to be moving toward a system that allots the administration of mental health programs by geographic area. There is also emphasis on mental health consultation.

It may be possible for the community mental health centers to provide teachers who are professional mental health workers. The contacts with school personnel might be beneficial for both parties to the transaction. This plan will be implemented by the St. Louis Public Schools and the Southwest St. Louis Community Mental Health Center. The mental health center will provide funding and staffing for a school within the geographic area of the center. The service to the school will be considered part of the community education program of the mental health center.

Confrontation Technique Applied to Delirium and Confusional States

H. H. Garner

Any patient approaching or recovering from stupor or coma may be described as delirious or confused. Any state of cerebral insufficiency due to oxygen lack, glucose or other essential substrates, disturbance in intracellular or extracellular enzymes, dysfunction of synaptic transmission or cell membrane biochemical systems can be of etiologic significance. States of delirium and confusion may be found in patients with severe anemia, fever, peripheral circulatory collapse, cardiac failures of any nature, pulmonary decompensation, hepatic, or renal failure.

The clinical picture varies from mild to marked slowing of the electroencephalogram and symptoms which include being quiet and having difficulty in recognizing people and surroundings, withdrawal from contact and expressing feelings of being weak, tired, and sleepy. Another syndrome may be evidence of cognitive disorder in the patient's slow responses, facial expressions of perplexity and memory concentration, and orientation defects as a communication exchange takes place. The muttering, incoherent patient may represent a very severe, acute form of delirium, or a state preceding degenerative changes of a permanent nature or death.

In delirium the individual is awake and responds to external stimuli although responses may indicate that the messages are undergoing distortion; perception, attention, memory, and thinking, and behaving are impaired but fluctuation in the degree of impairment is evident; defective reality testing is evident and past experience and knowledge are not used when responding to stimuli in the environment. Delirium may last from a few seconds to months and may be followed by seeming total recovery, residual amnestic states and dementia, or progress to stupor, coma, and death.

Although a patient in coma is not reactive to oral stimuli, not uncommonly the individuals responsible for the care of patients overlook the extent to which patients going into or coming out of states of stupor or coma are capable of receiving and comprehending stimuli. The individual with clouding of consciousness can be contacted by spoken stimuli which can affect him adversely or favorably. The patient's room should be lighted brightly; during the night the lights should be on; spoken stimuli should be direct and forceful and should penetrate the barriers against perception; stimuli which cast shadows and barely penetrate the perceptual barriers or those which form a background for reverie are undesirable; human contacts should be frequent and forceful enough to bring a message that "this is human contact outside of me and not in my dreams."

Feeding into the patient alerting, orienting, and attention-catching stimuli and information through confronting him with reality-based data is the psychotherapeutic element in treatment. The patient is confronted with: "This is a nice day, the sun is shining brightly."—"I have a glass of orange juice for you!"—"Monday is the visiting day, and I understand your wife is coming today."—"How

Condensed with permission from the *Illinois Medical Journal*, 137(1):71–73 passim, 1970.

do you feel on this March 21, the first day of Spring?" The therapist should be capable of functioning as a "programing machine" in which the voice tones of human kindness, helpfulness, and interest add not only information, but hope. Confrontation statements directed at control of regressive behavior followed by—"What do you think or feel about what I told you"—are introduced as the potentiality for using the will to regulate behavior seems to be within the grasp of the patient. For instance, for the patient who continues to be incontinent—"You can be a clean person. What do you think or feel about what I told you?"—may have significant effects in a short time.

An awareness of the disturbed perceptual functions is a distressing element in the patient's maneuvers to restore equanimity. The compliant attitudes of the patient to authoritarian commands plus the question—"What do you think or feel about what I told you"—create an awareness of the helper as a benevolent person who expects the patient to have the capacity for functioning on the basis of realistic perceptions of the universe. Repetition of the statement at frequent intervals can be supplemented by repetition by other personnel in contact with the patient.

The essential elements such as disorientation, grasp (ability to comprehend relationships among the elements in the environment), attention (selective influence which determines which aspect of or which stimulus object will be responded to) will be affected by the intruding confrontations which the patient will find difficult to evade.

As improvement occurs, the dysfunction in problem-solving and purposive behavior is used in selecting a confrontation to stimulate awareness of the need to use directed attention in controlling the thinking process—"You should think like the sensible person you can be"—"Stop thinking and behaving like a mixed up person"—"Use the good sense you have"—are examples. One may respond to the paranoid delusional content, often of a frightening nature—"Stop believing terrible things are happening all around you and that someone is harming you. What do you think or feel about what I told you?"

The feeling of a need for help and the response to appropriate contacts which emphasize the approach of help is evident in the verbalizations of patients in delirium. Confrontations penetrate the sensory barrier, they are recognized as an attempt at help, they awaken feelings of reassurance associated with the awareness of the arrival of help when one is in desperate straits. The repetitive contact has the tendency to alert, make the patient aware that he can choose to respond to external rather than internal stimuli, and demands action in a reply by the question—"What do you think or feel about what I told you?"—which furthers the reality-based interaction of the delirious patient.

Epidemiology of Tetanus in Narcotic Addicts

CHARLES E. CHERUBIN

The first report of the association of tetanus with drug addiction is more than 90 years old. Within the past 15 years, this phenomenon has become a major contributory cause of tetanus. A survey in New York City from 1950 to 1965 demonstrated that since 1955 the majority of cases has occurred in narcotic addicts. A similar situation exists in Chicago.

This study is concerned with changes that have occurred in the epidemiology of the disease between 1965 and 1968 and with a summary of recent investigations in this area.

Addict tetanus is most frequently seen in addicted women, in particular Negro women. Nonaddict cases are likely to be men and to be white. The addict cases tend to concentrate in East and Central Harlem, while the nonaddicts are distributed in all the boroughs. In the past three years this has changed very little.

Nonaddict cases display a summer seasonal concentration, while addict cases do not. Finally, there is an immense difference in fatality rate which has not diminished appreciably in the past three years.

If the characteristics of addict tetanus cases are compared with the characteristics of known addicts, one similarity and several dissimilarities are noted. There are corresponding age distributions, but the sex, race, and residence distributions are different. Addict tetanus cases are a sample of the addicted population that contains many more women, more Negroes, and more Harlem dwellers than would be expected from other samples of the addict population which do agree with each other to a surprising extent.

Differences in the distribution of a disease that lacks a subclinical state, as does tetanus, can be related to differences in susceptibility and/or to differences in the exposure of a population. Nonsusceptibility to tetanus, that is, resistance to the disease, would correspond to the presence of detectable circulation tetanus antitoxin. Since there is no naturally acquired antibody to tetanus toxin, its presence must reflect an artificial immunization with tetanus toxoid.

Serum samples were taken from 144 men and 113 women admitted to Morris J. Bernstein Institute for narcotic detoxification. Twenty-one percent of the men did not have protective levels of antibody, compared with 35 percent of the women. The difference in levels of protection between the sexes and between groups was small. A larger proportion of this sample of addicts possessed higher titers of antibody than did a sample of the New York City population which was recently surveyed for tetanus antibody.

The relatively high level of protection can probably be attributed to the immunization given by the City of New York Department of Correction at Rikers Island and the Women's House of Detention. Both the sample and other groups of institutionalized addicts have high rates of prison experience. At most, only twice as many addicted women are unprotected against the disease as addicted men. However, the relative risk factor for women must be on the order of six times. The lack of ethnic differences in protective antibody levels leaves

Condensed with permission from the *New York State Journal of Medicine*, 70(2):267–271, 1970.

unexplained the distinctive ethnic and geographic features of the epidemiology of this disease in addicts.

Out of 28 addicts with tetanus seen at Metropolitan Hospital 25 were "skin poppers," while over 85 percent of addicts admitted with other diagnoses were "mainliners."

Interviews were held with admitted patients concerning route of drug administration. Two to three times as many women as men addicts use "skin popping" (subcutaneous injections), they use this route for a longer time, and they consume more drug per day and take more injections. Because unsterile subcutaneous injections are apt to produce abscesses and because the causative agent of tetanus can produce its neurotoxin only under anaerobic conditions, these findings go far toward explaining the increased risk of tetanus in addicted women. Nearly 25 percent of women addicts from Harlem give histories of "skin popping" as compared with about 6 percent of women addicts from other areas.

Quinine may play a major role in producing tetanus. It is added to the "street drug," to provide a bitter taste similar to the taste of heroin. Quinine is a protoplasmic poison capable of producing sterile abscesses when injected parenterally. Within tissues it reduces the redox potential and provides favorable conditions for the growth of anaerobic organism. The absence of reports of tetanus in English addicts who obtain relatively pure narcotics strengthens this possibility.

Few hospitals are prepared to provide care for severe cases of tetanus, which require intensive 24-hour anesthesia, nursing, and medical care for periods of up to three weeks. A tetanus treatment center is needed in one of the Harlem area hospitals to receive and treat all diagnosed cases and provide a more adequate level of care.

The prevention of the disease is simple—immunization of all addicts seen in medical facilities and public institutions. Only the City of New York Department of Correction has an organized program of this kind at the present time.

Because of poor venous development, women turn to subcutaneous injection sooner than men. Why this should be the case in Harlem and not, for example, in Bedford-Stuyvesant is unknown. The relatively lesser degree of protection of women by circulating antibody, their more frequent injections, and their greater use of subcutaneous injections produces a unique urban epidemiology of tetanus. Tetanus is an "occupational" disease of addicts of whom women are more susceptible, more exposed, and more often diseased.

The exposure must be great since the population of addicts has nearly as high a level of protection by tetanus antibody as the rest of the population. If we assume a denominator of 60,000 for the addicted population, a rate of about 1 to 2 per 10,000 population exists. This rate is equivalent to the highest reported peacetime rates that occur in some tropical countries with a totally unimmunized population.

Severe Obesity as a Habituation Syndrome

David W. Swanson and Frank A. Dinello

It is estimated that about 40 million adults and children in the United States are overweight. Obesity is best viewed as having multiple causes—metabolic, neurological, psychological, and socioeconomic. It is like many other disorders in medicine, especially those in psychiatry; an exact cause-and-effect relationship and pathophysiology are unknown. Nevertheless, the clinician must conceptualize the relationship between his obese patient and food. If this patient controls his caloric intake no physical harm results and he achieves an acceptable weight. Unfortunately, such control is not routinely within the capacity of the obese patient, perhaps because of organic factors or psychological limitations, or a combination. The result is behavior typical of a habituation syndrome with food as the substance that is used uncontrollably.

Habituation or psychological dependence refers to compulsive use of a drug because of the relief or pleasure it affords but without the development of physical dependence, severe intoxication, or of those other effects usually considered detrimental to the individual or society.

Habituation and a habit-forming substance are considered more benign than addiction; a habit-forming substance may be so abused as to become addicting except that it does not produce physical dependence. A majority of the public probably is mildly habituated to caffeine, nicotine, or alcohol and it is of little significance. Some are addicted to alcohol because of the intoxication produced, the overpowering desire for it, the increasing amounts consumed, the detrimental effects associated with it, and the possibility of a tolerance-withdrawal component. Narcotics are addicting drugs, yet in the terminal cancer patient they may produce a physical dependence and a need to take the drug but a genuine psychological dependence does not exist. The habituation-addiction differentiation is, thus, ambiguous. Most important to the clinician are the patient's compulsive use of the drug, psychological dependence, and the destructive effects produced, irrespective of the habit-forming or addicting substance used.

Subjects were selected on the basis of a body weight exceeding an ideal weight by at least 50 percent. They had to be motivated for severe dietary restriction and receptive to hospitalization on a metabolic research unit for a minimum of two months. Patients with overt psychosis or severe personality disorder were excluded. Subjects were maintained on a moderately restricted caloric intake for approximately 10 days prior to starvation while physical status and metabolic baseline values were established. The starvation regime was explained to the patient but no exact length of starvation was established.

The starvation technique consisted of total elimination of caloric intake. A daily intake of fluids, B-complex vitamins, and potassium bicarbonate was required. Physical activity was not restricted but excessive perspiration was discouraged. Extensive physiological and metabolic monitoring was done on a rigid schedule. Observations of behavior were made prior to, during, and after starvation. Twelve

Condensed with permission from the *Archives of General Psychiatry*, 22(2): 120–127, 1970.

subjects were seen for psychiatric evaluation prior to starvation and twice weekly for the duration of hospitalization. Three subjects were interviewed in retrospect about starvation. In all 25 subjects the medical chart, daily nursing observations, social history, and available psychological testing were reviewed.

Twenty-five subjects (24 men and one woman) were studied. Age range was from 23 to 55 with an average of 39 years. Weights prior to starvation ranged from 198 to 473 pounds and weight loss was from 22 to 124 pounds.

Of psychological interest is the loss of appetite in all subjects paralleling the metabolic acidosis caused by breakdown of fats. The acidosis reached a nearly maximal value in 48 hours and physical sensations of hunger were usually absent thereafter. Although other metabolic changes accompany starvation, none of the subjects experienced any sustained physical ill effects. The minor physical discomforts experienced by some subjects were light-headedness, mild headache, abdominal cramping early in starvation, and a later occurring unpleasant taste.

For all subjects food was the focus of life. Although they minimized their food intake, like the alcoholic rationalizes his drinking, most admitted their excessive eating. Food was the source of greatest pleasure and this included not only eating it but working with it. Nine were employed as cooks and five prepared meals in their household. Two other men spent several hours a day in restaurants where they not only ate excessively but also socialized. Some admitted consuming 6,000 to 10,000 calorie meals. The evening would begin with extensive preparation of the meal with consumption to the point of physical discomfort (distention, nausea, vomiting), drowsiness, and finally sleep.

Most subjects reported specific foods which had intense appeal; once they begun consumption there was no stopping. During diet efforts some avoided these foods for fear they would not stop eating. Two subjects admitted to nocturnal eating. One regularly awakened three times a night, would get up to urinate, and proceed to the kitchen.

Besides the pleasurable affect produced by eating, most were convinced they obtained some relief from anxiety and frustration by eating. After experiencing what they felt was unreasonableness of their customers, bosses, or wives they found privacy and food soothing. Yet, as severe fatness produced shame, guilt, and isolation, the subjects complained of unhappiness and loneliness. This feeling of sloppiness and being unlike other people was the principal stated motivation for starvation.

Sixteen had intermittently consumed moderate to large quantities of alcohol, usually beer. Some had switched to soft drinks and two drank 12 to 15 bottles daily. One subject was considered an alcoholic.

Prior to starvation none had overt psychotic or neurotic disorder. Ten had diagnosable personality disorder. These disorders were ingrained maladaptive patterns that had moderately disrupted social, occupational, or interpersonal functioning. Prior to starvation these people were not problems in the hospital for they were generally compliant, self-doubting, optimistic about what others could do for them, and desirous of finding an answer to their weight problem.

Observations during starvation—The first evidences of a stressed state were efforts by the fasting subjects to structure their time beyond the al-

ready extensive routines demanded by the research setting. Most patients established elaborate schedules involving gym work, walking, occupational therapy, reading, painting by number, and keeping weight charts. Additional evidence of stress was an increasing preoccupation with food. They talked in detail of favorite dishes and the majority collected recipes and pictures of food. Dreams about food were common. Two subjects had their wives bring in pastry and insisted on watching families and staff eat it. "Cheating" was also indicative of stress. All subjects thought of it but the exact incidence is unknown. Three men admitted it. One went to a vending machine area and ate several sandwiches. Despite the warning that the metabolic studies would expose anyone going off starvation, several subjects insisted they had devised a timing of caloric intake which escaped detection. When violation was suspected, subjects would become indignant, or give excuses to explain a weight change.

Dependence on the staff increased as starvation progressed. Subjects would request exceptions to the rules or explanations of common procedures. Cooperation gradually diminished. Some subjects produced uncertainty about when to terminate starvation. Although unhappy and wanting to eat they would insist on prolonging starvation. If medical-psychiatric reasons were given for termination they were disgruntled.

Overt psychopathology was observed during starvation in 17 subjects. The disorder was often mild, did not require treatment, but was significant because it represented a change from admission.

The most obvious clinical signs were in the subjects with paranoid trends. These persons went through a period of apprehension about physical condition, family, or finances. They attributed their problems to staff inefficiency. Suspicions, accusations, and threats were made.

Although at least 12 subjects manifested depressive features during starvation, only four had this as a prominent finding. These persons usually experienced a period of apprehension about themselves or their family. Feelings of hopelessness were expressed and helplessness was evident. Two felt they were unattractive when thin and described feeling hollow or appearing "skinny," although both were still obese. None was psychotically depressed.

Two subjects developed severe anxiety disorder, terminated starvation, and felt it urgent that they leave the hospital. They denied hunger but finally explained they must eat or go "crazy."

The subjects with changing character patterns during starvation did not often complain of discomfort. More than other subjects these patients experienced a sense of well-being during starvation.

Starvation was terminated according to plan or for medical reasons in 15 subjects. In the remaining, termination was requested or resulted from other psychological factors resulting in a 40 percent incidence of withdrawal in highly motivated obese persons.

Follow-up observations—The subjects were re-fed on strict diets designed to continue weight reduction. Most were confident they could continue successful dieting after discharge; none did. Within a year, all except four were at a weight equal to or exceeding that upon admission.

A possible explanation for these symptoms associated with food restriction is that starvation will produce psychological changes in any subject—

obese or nonobese. The stress of marked food restriction in persons of normal weight is documented: psychological changes are reported in experimental studies and in accounts of unintended starvation (famine, concentration camp, and geographical isolation). In these instances, however, the starved persons had some caloric intake and, thus, an appetite. In the instances of unintended starvation the victims were facing a life-threatening situation—from a hostile environment and from a weakened physique with disordered metabolic functions. The obese subjects had no physiological need for food but, nevertheless, manifested the behavior of a stressed person.

There are clinical, if not etiological, parallels between superobesity and a habituation-addiction disorder such as alcoholism. A pattern of social and physical discomfort develops which initially motivates some persons to treatment. Upon admission both types of patients manifest a variety of characterological or underlying psychiatric problems. Motivation for restriction of the food or alcohol is initially good and control of intake is possible. With prolonged restriction, a certain number will evidence an increase in personality or psychiatric problems. In some subjects before discharge, and in the majority afterwards, there is a return to secretive and excessive use of food or alcohol. Despite logic, resolution, and adequate caloric supply, adherence to a diet is difficult.

The excessive use of food is a pattern established early in superobese persons; the severest obesity tends to occur in the individual who early uses food to produce pleasure or reduce psychological or physical disequilibrium or both. It remains unclear what causes this excessive need for food. The following have been posed: overactive appetite center, impaired satiety center, disordered glucostatic mechanisms, alteration of fat enzymes, conditioned behavior, symbolic satisfaction of unfulfilled wants, anxiety, depression, desire for isolation, and socioeconomic frustration. Whatever the cause, it produces subject unrest for the obese person, either directly or by conflict with the environment. Until an exact etiology is found, the clinician treating severe obesity can profitably regard the condition as a habituation syndrome. This places the difficulty of treatment in perspective and emphasizes the necessity of using the multiple therapeutic approaches now utilized in other addictions.

Geographical Flight and Its Relation to Crisis Theory

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One strength of America lies in the ability of its people to move, to adapt, to adjust to new environments. The majority of people move and adjust independent of outside intervention. But some move out of weakness and little is known about them.

Travelers Aid Societies have attempted for nearly 50 years to meet the emergency needs of those who are in trouble as travelers. We have recently realized that a large segment of the mobile people who apply or are referred to Travelers Aid are in flight as a result of crisis. We have coined the term "crisis-flight" to describe a definite pattern of travel wherein "motionness" and geographical fleeing have become a chronically episodic way of coping.

We suggest that it is a condition of sufficient frequency and severity to warrant research both to understand and evaluate its meaning and to find appropriate methods for prevention and treatment.

We arrived at the concept of crisis-flight as we tried to work with a mounting case load of traveling people who were immobilized upon arrival in our city, seeking overnight food and shelter and a ticket to continue their travel, often arriving at a train or airline terminal too emotionally flattened out to participate in decision-making for themselves, or brought to us unable to identify themselves and enmeshed in fantasy or delusions.

Unlike hoboes and gypsies whose individual and cultural identities are expressed through travel, or the pioneers moving to new frontiers, or the questful, if not always fruitful, mobility of migrant workers—this group of chronic wanderers is distinguished by negatively resolved crisis, appearing to find the disequilibrium of flight to be their most frequent coping state.

The caseworkers of Travelers Aid of Washington, D.C. face the need to develop techniques of helping severely disturbed people in crisis. Because it is the Federal City, Washington attracts many who fantasize that a miracle will take place if only they can see the President, the Patent Office, a senator, the FBI. Another group seems to trek aimlessly through the city intent on perpetual flight. Another group, escapees and elopers from mental hospitals, nursing and convalescent homes, and/or their families, presents a unique problem in that the institutions or relatives are often not interested in their return. The trend toward outpatient treatment has freed those prone to flight to act out in crisis-flight.

To differentiate between crisis and crisis-flight, we should note that there are groups for whom we feel the crisis studies *have* provided effective techniques.

One group would be the well-put-together, planful travelers, who experience crisis such as a stolen purse, sudden illness, cultural shock, or some other momentarily immobilizing emergency. These situations can be severe and acute and of varying duration. Our skills have been adequate to help them through relatively brief, but often intense intervention.

Another group would be those who occasionally use geographical flight as an alternate response. Flight may be an isolated incident, such as a

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Condensed with permission from the *American Journal of Orthopsychiatry*, 40(1):53–57, 1970.

child running away from home for the first time, an adolescent attempting to emancipate but willing to return home, a young bride returning to her mother after her first marital quarrel.

We are excluding one group who travel but are not involved in either crisis or flight: people for whom travel is a vocational way of life, who have found healthy resolution in recurrent or perpetual travel, such as the truck driver, salesman, seafarer. We are also excluding the affluent, whose incomes permit them to seek excitement and escape through perpetual world travel, and who may be in crisis-flight. These people do not often come to the attention of social agencies.

As our caseload began to reflect a sharp increase in the numbers of travelers who were emotionally disturbed and in flight, the caseworkers observed that the interruption of continued travel was a more severe crisis than the unresolved crisis from which they were fleeing. This is the point at which we see the onset of crisis-flight. For clients for whom this had become a recurrent or a continuous behavior pattern, sharp distinction had to be made between those who should be helped to keep moving and those who should be encouraged to stabilize.

In a recent review of our caseload, we found that two-thirds of the applicants appeared to be in a more or less continuous state of crisis-flight, able to function fairly adequately when on the move but with little capacity to cope when not moving. They exhibited varying degrees of disorganization and dysfunction, with some 300 or more in severe delusional states. On our first contact, several of them became more acutely psychotic when we did not immediately expedite their continued moving.

Some of these clients broke contact and found other means of pursuing their need to keep moving because we could not establish a strong enough relationship to help them stop and reconsider their choice of goals. Some lost their capacity to deal with reality and required emergency hospitalization when funds were not provided for their continued movement. We have been able to help a few to become stabilized in the community with a job—at least temporarily. How long they will be able to sustain a job and what their reaction will be when the inevitable next crisis occurs in their lives are open questions.

A more basic question is whether it will be possible to refine diagnostic skill to be able to pinpoint who can and should be halted in their flight.

If our hypothesis of early damage as a predisposition to crisis-flight is correct, then the likelihood of change for many such clients is slim. Rather we need to look to the onset of flight —the first instances of flight as prime time for more hopeful intervention. Understanding of the interplay between early childhood trauma and the first response to major crisis in adolescence or early adulthood may be the key to any substantial effort to reduce the wasteful phenomenon of chronic crisis-flight in our American population.

The Organization, the Administrator, and the Mental Health Professional

THOMAS DOLGOFF

The pace and sweep of social, political, technological, and demographic changes are transforming our lives in fundamental and unpredictable ways. They are placing strains on all social institutions, including organizations where mental health professionals and administrators work together.

"Professional" has a variety of meanings. Here it means a person in a socially approved occupation that requires long formal training in a specialized field at an institution of higher learning. Professionals have a code of ethics, and a service ideal in which personal profit is subordinated to the client's interest. The professional's expertise is manifested by symbols such as licenses, diplomas, and certifications. His relationships with his clients are usually confidential and privileged. Professional norms require that the interaction be initiated by the client and terminated by the professional. The professional usually is the sole judge of the validity of his decisions.

In autonomous professional organizations, the professional employees have responsibility for defining and implementing goals and maintaining standards. Such organizations include general hospitals, therapeutic psychiatric hospitals, medical clinics, and some colleges and universities. In heteronomous organizations, the autonomy granted professional employees is small. Examples are some libraries, secondary schools, and social welfare agencies, small religious colleges, and firms engaged in applied research.

Condensed with permission from *Hospital & Community Psychiatry*, 21(2):45–52, 1970.

In professional organizations, the professional tends to create his own role. He negotiates for space, facilities, staff, and money. Although the effort to control his working conditions is not unique to the professional, such control is important to him because his reputation and career may depend upon them. The professional also engages in negotiation about organizational policies that threaten his professional values and claims and his relationships with other professional groups.

Professional groups tend to divide into subgroups, sometimes on an interdisciplinary basis. They do so on their own initiative. But as each segment grows, it may demand administrative recognition. This segmentation increases the likelihood of conflict and competition, because different groups may have different requirements and ideas about what the organization should do. Each group and subgroup, in its efforts to influence objectives, policies, and the use of resources, uses political groupings such as faculty senates and hospital staffs, which engage in political tactics and form parties or alliances on the basis of common interests.

Recent activities of teachers, clergymen, and mental health professionals on picket lines and doctors at "healins," the doctrine of civil disobedience as a matter of conscience, and the spectacle of armed students facing armed troops on campuses have one element in common: they challenge the legitimacy of formal authority. Repudiating hierarchical authority as the indispensable means of managerial control is a recurrent theme in crit-

icisms of conventional theories about the management of industrial workers and executives, and it is a salient characteristic of professional organizations.

Modern technology requires large numbers and varieties of professional and technical personnel. Power has passed from the holder of land to the holder of capital and now to the holder of technical skills.

Nowhere is the power of the professional more clearly seen than in hospitals. If a hospital is unable to secure enough nurses to meet accreditation standards, or if the nurses fail to meet licensure requirements the hospital may collapse. When the administrator is so dependent upon the nurse, how can he have any effective authority over her? Virtually all industrial organization theory is built on military and ecclesiastical models, with threats of excommunication or court-martial, from which the army and the church have already departed.

Today sanctions and threats are ineffective, because workers have gained protection through unions and professional organizations, and because they have an increasing number of job and career opportunities. Decisions about salaries, employee benefits, and working conditions have become the prerogative of professional organizations over which the administrator has little influence and no control.

Mental health professionals resist authority not only because of the realities of power relationships, but because of their norms and self-concept as professionals. They are reluctant to be judged, especially by persons whom they do not recognize as competent to judge them and when the standards of judgment are subjective. The departmental structure often requires superiors to make decisions about matters of which they are not the best judges. Yet they must plan, evaluate performance, authorize leave, set salaries, and assign office space and secretarial assistance. It is unlikely that one person will have wisdom or expertise in all areas, even if he may have it in some.

Authority is one of the bulwarks of standard management theory, and motivation is another. No organization can come into being or survive unless qualified individuals can be induced to join it and contribute to its purposes. The carrot-and-stick theory of motivation does not work for professionals who have reached an adequate subsistence level and are motivated by the higher-level needs for autonomy, achievement, confidence, status, recognition, and self-fulfillment. Few mental health organizations have been able to develop the machinery and methods needed to assess those needs realistically.

Any mental health administrator can provide illustrations of how needs, values, and goals collide with one another in multidisciplinary organizations, and with those of the institution. While psychologists, their professional associations, and civil-service classification systems may place a higher value on psychotherapy and research than on psychological testing, the superintendent of an understaffed hospital with high patient turnover may have different priorities. Social workers and hospital superintendents have reason to disagree about the relative importance of casework and history-taking. Public hospitals are subject to pressures from the community or from physicians or legislators to admit patients when there is no room, when the patients are not treatable, or when there is a shortage of staff.

A tenet of every profession is that the profession alone is capable of judging the qualifications of its mem-

bers and evaluating performance. Yet an organization may find it necessary to recruit, train, rate, and compensate professional employees on the basis of its own criteria. In public institutions there may be legal constraints such as civil-service rules and rigid local salary scales.

The officials of many organizations that employ professionals must arrogate to themselves the right to select the organization's customers, clients, patients, or problems. Because most professional schools emphasize that the professional's free choice in such matters is his inalienable right, the organization's screening processes are a frequent source of conflict.

The conflicts grow more severe as new professionals and specialists enter mental health organizations. Sociologists, anthropologists, information specialists, educators, mathematicians, computer technologists, are all struggling for recognition and status. Because resources are limited, professionals as well as administrators think in "zero-sum" terms, where one person's gain is another's loss. Recognition and status must be wrested from the established groups. Conflicting goals are of special significance in mental health institutions: they have profound effects on patient behavior, and they pit organizational requirements against the professional values to which many staff members are committed.

The administrator must do more than arbitrate those conflicting forces. He must interpose organized convictions of his own about the direction such resolutions should take. How he is to do so remains an unanswered question. That is one reason that many presidencies in universities remain unfilled despite the salaries, status, and power those positions confer.

However, the administrator's situation is seldom too dismal. Once he is able to induce professionals to remain in sufficient numbers and quality, his own power, paradoxically, may increase. As each professional group acquires more power and competes with other groups for status and resources, the conflicts must be kept within reasonable bounds or the individual members of the groups will be unable to deal with their personal stress or protect their jobs.

Because only management can adjust competing claims and because the professional is dependent upon those adjustments, he loses power while management's power and influence are enhanced. The increased independence of each professional group requires increased coordination if the organization's objectives are to be reached and if internal balance and equity are to be maintained; that coordination also requires tighter rather than looser administrative controls.

Despite the tensions between professionals and the organization, their interests converge at many points. The organization needs the scientists' expertise, and provides the salary, facilities, and access to other specialists that many professionals must have to do their work. The complexity of modern technology makes it impossible for many professionals to function as "free professionals."

Some organizations have established multiple career lines for professional people to provide "professional ladders" to higher positions, with multiple ranking systems and multiple salary scales. Such rewards may be supplemented by intrinsic and peer group rewards, special recognition and encouragement for participation in the affairs of professional organizations, and financial incentives for specialty-board certification and other honors.

Findings about influence and au-

thority among physicians suggest that separating administrative from technical supervision may reduce tensions. The physicians comply more readily with administrative directives than with those involving clinical work. Some organizations are using collegial control (control exercised by colleagues) for recruitment and placement as well as for evaluation of performance and quality control.

In some organizations, first-line administrators act as linking pins between professionals and administrators and among professional groups. First-line administrators are those immediately below the top level in large organizations who are assigned as working members of professional groups. By identifying with the professional group and with the higher levels of the administrative hierarchy, and being aware of the viewpoints, desires, and constraints of all, they reduce friction and misunderstandings and promote cooperation. As the man in the middle, the first-line administrator often has considerable discretion in interpreting and applying directives emanating from above, so as to meet the needs of the professional group of which he has firsthand knowledge.

First-line administrators are essentially staff assistants. They may engage in collecting, analyzing, and collating information; drafting procedures and other instructions; preparing grant requests; determining budgetary and personnel requirements; determining the need for and procuring space, equipment, and supplies; and developing reporting systems. They may serve as neutral third parties, who understand the problems of each discipline in the group but, because of their impartiality, are accessible to all for the ventilation of feelings as well as for communication.

The range and complexity of an organization's administrative problems are often a result of its diversity of programs and rate of change, rather than of size. First-line administrators may be used to advantage not only in large organizations, but also in the relatively small but complex ones, such as the Menninger Foundation.

We have developed two types of first-line administrators—the administrative generalist, who is responsible for all administrative functions within a department or program, and the administrative specialist, who works in all departments on such specialized functions as personnel administration or financial management.

Organizations often encounter difficulties in finding qualified people for the key spots. First-line administrators require technical competence, keen analytical powers, speaking and writing skills, discretion, and tact—especially for the "fraternal-permissive" function. They must have a passion for anonymity, because they must make program contributions while functioning in a subordinate position. Training in behavioral sciences as well as management is desirable, as such people must be familiar with the technology, concepts, and viewpoints of diverse professional and occupational groups, and must be able to speak the languages of the biomedical engineer, the accountant, the cook, and the psychoanalyst.

A difficulty is fitting specialization into a hierarchical framework. In a less technologically advanced era, the department head was the most skilled, and the conventional model, with its chain of command and dependence on rules, was relatively efficient. That model breaks down for professional as well as industrial organizations confronted with rapid and unexpected changes and the complexities resulting

from increased size and greater diversity.

The imbalance between ability and authority is apparent in all mental health organizations. Our culture defines success as moving up the ladder, but there are a limited number of hierarchial positions. Admission to the hierarchy by "merit" does not always meet the professional's definition of merit, because the applicant's compatibility, loyalty, and appearance must be considered, as well as specific administrative skills. The specialist must give up work for which he is trained and do work for which he is not trained. The standards by which he is judged become vague and subjective because of the time between efforts and results, as when he undertakes to change the organization's directions or its emotional climate.

Technological virtuosity and innovative ability are important to professionals because their status, career, and reputation depend on them. Such qualities generate conflict, which bureaucratic organizations discourage by centralizing decision-making inflexibly at specified hierarchical levels; there novel or unorthodox ideas as well as disagreements may be blocked.

Planned and programed overlap in job assignments and in the membership of committees, task forces, and councils can improve communication and coordination. To the extent that it creates conflict, it can encourage innovation. When activities overlap, problems can be viewed from different perspectives, and a truer picture may emerge. Administrative as well as scientific problems are so multifaceted, and reality is so hard to discern, that the processes of solving problems are analogous to those of the proverbial blind man in describing an elephant. The imaginative use of group processes, overlapping membership in problem-solving groups, and the linking-pin type of organization in which staff members are at the same time supervisors and subordinates are other devices for reducing organizational rigidities.

Frederick Taylor, who was called the father of scientific management, advocated the concept of functional management, in which each aspect of the worker's task was commanded by an expert in that area. A worker was responsible to eight foremen—a speed boss, a repair boss, an inspector, and so on. That type of organization has been superseded by Weber's bureaucratic model, because a system of multiple subordination exposes employees to the stresses and insecurities of contradictory orders. Weber's model is the stereotype of good organization in our culture because it is based on our values of responsibility, authority, command, obedience, dominance, and submission. With the exception of responsibility, those are the values that professionals reject.

We might consider adopting functional organization in mental health facilities. In a functionally organized hospital, one person might be responsible for staff development throughout the hospital, another for quality control, and a third for the allocation of professional time within and between all departments. Authority can be related to ability, and qualified people are more easily found for the narrowed functions. Functional organization has advantages and disadvantages. It encourages cooperation and looking at problems from the point of view of the organization as a whole. But it may be confusing to employees, because responsibility is hard to fix, and workers are less secure when they have more than one boss. Those disadvantages are less significant in professional organizations than in industrial organizations.

Functional organization is attractive

because it reconciles organizational and individual and professional goals. It implies delegation of administrative authority and staff involvement in policy formulation and execution. It presents problems in coordination and control. The advantage is that the pluralism and conflict will tend to force attention on purposes and goals, rather than professional territorial claims.

Although the suggestions I have offered for improving relationships between administrators and professionals are still tentative and untested, they offer promise if we can be wise and patient enough to study them carefully and experiment with them prudently. Research will be required to translate these concepts into action in professional organizations, and to close the gap between management theory and practice. Many professionals as well as administrators will be reluctant to drop the hierarchical models when they do not know what problems other models may present. Group pressure may prove no less tyrannical than hierarchical control. If the executive is to discharge his responsibilities, where will he secure the power to act as more than an arbiter of conflicting desires, and to make the difficult changes that survival and progress in the modern world require?

The fact that administrators are becoming professionals in their own right increases the difficulties of differentiating and reconciling the "professional" and "administrative" roles. The mental health administrator cannot afford to forget that these terms are abstractions that may conceal as well as reveal complex and confusing realities.

Alcohol Level and Home Accidents

HENRY WECHSLER, ELIZABETH H. KASEY, DENISE THUM, and HAROLD W. DEMONE

Lack of systematic research on the important public health problem of the role of alcohol consumption in home accidents prompted this study. The sample was comprised of patients age 16 and older, who were admitted to the emergency service of Massachusetts General Hospital from October 1966 through September 1967. Patients were interviewed during one 8-hour shift of each 24-hour period for 363 days. This procedure resulted in a one-third sample of all shifts, with an equal distribution of shifts, days of the week, and months of the year.

Excluded were patients admitted for psychiatric reasons including alcoholics without injury and persons suspected of attempting suicide by ingestion, those receiving postoperative or continuing care, and those with dental problems of nontraumatic origin.

The interview obtained a description of circumstances surrounding the accident or onset of acute symptoms as well as information concerning drinking behavior. If the patient was too ill to be interviewed, information was obtained from hospital records or from an interview with the patient or a visitor during confinement.

A Breathalyzer reading taken during the interview was used as the index of blood alcohol concentration. If a breath sample could not be procured but a blood sample drawn by the admitting physician was available, the blood sample was used. The interviewer also attempted to detect the odor of alcohol on the breath of the patient at admission.

A home accident was defined as "any wound or damage to a person occurring in a home or its premise as a result of a chain of events the consequences of which were unintended." The 1965 revised International Classification of Diseases was used to code all accident and nonaccident cases.

Information was collected on 8,461 patients. Breathalyzer tests were done on 74 percent of the patients. Of the patients for whom no Breathalyzer reading was obtained, other indications of alcohol involvement were used. No information concerning alcohol involvement was available for 863 persons. Only 224 persons refused to take a Breathalyzer test. The sample on which the analyses were made comprised 6,844 patients; 5,622 for whom Breathalyzer readings were available and 1,222 with other indications of the presence or absence of alcohol.

Home accident injuries—A positive Breathalyzer reading was obtained from 23 percent of the patients with home accidents injuries, a significantly higher alcohol involvement than for nonaccident patients or patients with occupation accident injuries. Patients with transportation accident injuries or injuries resulting from fights or assaults had higher percentages of positive alcohol readings than those with home accident injuries. Readings for patients with home accident injuries did not differ from those for patients with "other" accident injuries.

Comparison of accident cases—Transportation accident patients had the greatest proportion of positive readings. Of 404 patients, 349 were drivers or passengers of motor vehicles

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and 44 were pedestrians. Occupation accident patients had the lowest proportion while the proportion for home and "other" accident patients was intermediate.

Comparison of nonaccident cases—Because nonaccident patients with circulatory diseases, digestive diseases, symptom disorders, or other medical conditions did not differ in alcohol levels, these cases were combined in the analyses.

Accident versus nonaccident cases—Twenty-two percent of the accident cases involved alcohol as compared with only 9 percent of the nonaccident cases.

Accidents by type versus nonaccidents—All types of accident cases differed significantly from nonaccident cases with respect to levels of alcohol.

Fights and assaults—More than half the patients with injuries resulting from fights or assaults had positive alcohol readings. When fights or assaults were compared with nonaccident cases, a significant relationship was present. A signficant relationship also was found in a comparison of cases of fights and assaults with all accident cases.

Other signs of alcohol involvement—Positive venous blood tests or alcohol breath occurred significantly more often among transportation accident patients than among patients injured in any other type of accident. Unlike positive Breathalyzer readings, other positive signs of alcohol were not less frequent among occupation accident patients. Positive venous blood tests or alcoholic breath were observed with approximately equal frequency among home, occupation, and "other" accident patients.

Breathalyzer results controlled by time of drinking—On admission, patients were asked whether they had consumed alcohol after the accident or onset of symptoms. Of 5,248 cases for which information was available, 600 patients replied that they had a drink after the episode.

The patients were divided into two groups: those who had consumed alcohol after the accident or symptom onset (group 1) and those who had not (group 2). Group 2 was divided on the basis of how soon the patients arrived after the accident or symptom onset: less than 3 hours, 3 to 6 hours, or 7 or more hours. The presence of alcohol was highest in group 1 (38.2 percent with a positive Breathalyzer reading). For groups 2a, 2b, and 2c, the frequency of positive alcohol readings was related to delay between accident or onset of symptoms and arrival at the emergency service. The major relationships held whether alcohol was or was not consumed after the accident or onset of symptoms and regardless of the time interval between the episode and arrival in the emergency service.

Relationship of alcohol involvement to reason for admission, controlled for social background characteristics—Because sex, age, marital status, and social class have been significantly associated in other studies with involvement of alcohol, it was necessary to control for these variables.

Reason for admission was related to the presence of alcohol for both men and women. Persons of both sexes who were admitted for accidents had a higher frequency of positive alcohol readings than persons admitted for nonaccident reasons. For both men and women, occupation accident injuries had the lowest frequency of positive alcohol readings. Persons admitted for injuries resulting from fights or assaults had the highest frequency of positive readings as compared with persons admitted for other reasons.

Patients were divided into four age groups: 16 to 25 years, 26 to 45 years, 46 to 65 years, and over 65 years. In

each age group alcohol involvement was related to reason for admission. For all groups, accident cases had a higher frequency of positive Breathalyzer readings than nonaccident cases. In nearly all age groups among the accident cases, transportation accident injuries were highest in percentage of positive readings and occupation accident injuries were lowest.

Marital status was studied by comparing persons who were single, currently married, or previously married (widowed, divorced, or separated). In each category, the association between alcohol level and reason for admission was significant; a higher frequency of positive alcohol readings was found for accident patients than nonaccident patients. Among accident patients, the highest proportion of positive readings was found for transportation accident injuries and the lowest for occupation accident injuries. The highest frequency of positive readings was found among patients with injuries resulting from fights or assaults.

More accident patients in all social classes had positive alcohol readings than nonaccident patients. Patients with transportation injuries had the highest frequency of positive readings and those with occupation injuries, the lowest. Among all social classes, patients with injuries resulting from fights or assaults had uniformly high frequencies of positive alcohol readings.

Analysis of home accident injuries—Home accident injuries were examined in greater detail to learn whether the presence of alcohol, as determined by the Breathalyzer test, was associated with the external cause and nature of the resulting injury. Alcohol involvement was greatest among the patients with head injuries, lacerations, and contusions.

The study is correlational and cannot be viewed as establishing a causal relationship. The comparison group of nonaccident cases may not have been representative of the community with respect to alcohol level since it was composed of ill persons seeking treatment. Finally, the alcohol level of the patient was measured at the time of admission not at the time of the accident. But the findings are consistent and clearcut and implicate alcohol as a factor in home accident injuries as well as in injuries from transportation, occupation, and other types of accidents and in injuries resulting from fights or assaults.

Mental Health and the Law

Recent Cases

Minor v. United States and Buie v. United States, U. S. Supreme Court, December 8, 1969

Petitioner Minor was convicted of selling narcotics without making out a written order form, in violation of a provision of the Harrison Narcotic Act. Petitioner Buie was convicted of selling marihuana in violation of the requirement of the Marihuana Tax Act that the buyer have an official order form for the transaction. Both men appealed to the U.S. Supreme Court on the ground that the statutory obligation to sell only in pursuance of an official order form violated their Fifth Amendment privilege against self-incrimination. They cited the recent Leary decision [395 U.S. 6, 1969] which held that the Marihuana Tax Act violated the self-incrimination safeguards of marihuana purchasers and importers.

The Supreme Court, in a 6–2 decision, upheld the convictions. The statutory scheme, the opinion stated, does not force illegal narcotics and marihuana peddlers to incriminate themselves, because as a prior court decision (Leary) held that purchasers cannot be prosecuted for refusing to comply with the order form requirements, "there is no real and substantial possibility" that a seller would be able to find a buyer willing to fill out the form. The only practical alternative for the seller under the law is not to sell narcotics, the opinion said.

Justices Douglas and Black, dissenting, argued that "the Government is punishing an individual for failing to do something that the Government has made it impossible for him to do—that is, obtain an order form from the prospective purchaser prior to making a sale. . . ." They relied upon a concession by the Government in oral argument that "it is impossible to secure an order form for the purchase of heroin. . . . The order forms may only be used to purchase a lawful drug for a lawful purpose. . . ." They would hold the paper work requirements of the taxing provisions violate the Fifth Amendment privilege against self-incrimination.

Carlos v. New York, U. S. Supreme Court, December 8, 1969

Carlos, a New York shopkeeper, was found guilty of selling obscene matter in the form of "girlie" magazines. The New York Court of Appeals affirmed the conviction. On appeal to the United States Supreme Court, the defendant charged that the New York court had ignored a 1967 Supreme Court ruling that held similar "girlie" magazines not obscene.

The Supreme Court disposed of the appeal by summary action: without granting a hearing, it reversed, citing the 1967 ruling. Chief Justice Burger, in a brief dissent, in which he was joined by Justice Harlan, made known for the first time his view as to obscenity laws. He cited two previous Harlan dissents in which that Justice stated an obscenity doctrine that treats Federal and State laws differently. Justice Harlan would uphold only those Federal laws that suppress "hard core" obscenity. He would, however, grant States broad discretion to curb obscene material, holding that the First Amendment does not bar States from curtailing obscenity unless the local officials' definition of obscenity is "wholly out of step with current American standards."

Crittenden v. Crittenden, Supreme Court of Appeals of Virginia, June 16, 1969; 38 L.W. 2003

A Virginia statute permits divorce on the basis of two years' uninterrupted separation without cohabitation. The plaintiff's husband brought a divorce action under this law, noting that there were two years' uninterrupted separation without cohabitation while his wife was committed to a mental institution.

The Court refused to grant the divorce. Although the statute did not contain any exception applying to a situation where separation results from the commitment of one of the parties for mental incompetence, the Court said it was of the opinion that "the separation contemplated by [the statute] must be of parties who are sufficiently competent to be conscious of the fact that the act of separation has occurred."

U. S. v. Vuitch, U. S. District Court, District of Columbia Circuit, November 10, 1969

A physician indicted for performing abortions in violation of a 1901 statute brought a motion to dismiss the indictment on the grounds of vagueness of the statutory language constituting denial of equal protection. He relied heavily on People v. Belous, a September 1969 decision of the California Supreme Court, in which that court struck down the statutory phrase "necessary to preserve" of that State's abortion law as so vague and overbroad as not sufficiently satisfying the due process clause of the Fourteenth Amendment to the United States Constitution.

The court granted the motion, holding that the abortion law failed to give that certainty essential in a criminal statute by being impermissibly vague in using the word "health" and in requiring the physician to make the decision at his peril. The court cited Belous as to the general uncertainty in the phrase "necessary for the preservation of the mother's life and health," and added that such a vague statute is particularly subject to criticism when it impinges on significant constitutional rights such as personal privacy. "The jury's acceptance or nonacceptance of an individual doctor's interpretation of the ambivalent and uncertain word 'health,' the court said, "should not determine whether he stands convicted of a felony, facing ten years' imprisonment. His professional judgment made in good faith should not be challenged." The fact that the statute makes no provision for consideration of the woman's mental health, as well as physical health, the court said, puts the physician in a "particularly unconscionable position."

Noting the trend toward judicial extension of right-of-privacy and personal liberty concepts in the field of marriage and sex, the court said that these matters "may well include the right to remove an unwanted child at least in early stages of pregancy. . . . Matters have certainly reached a point where a sound, informed interest of the state must affirmatively appear before the state infringes unduly on such rights." Although the State has an interest in prohibiting abortions by those not competent licensed practitioners of medicine, it has no interest in keeping physicians from performing them.

A motion for dismissal of an indictment brought against a nurse's aide for performing abortions also was disposed of in this decision. The defendant, Boyd, raised several arguments, ranging from women's rights to public policy on population growth, most of which issues were not com-

mented upon by the court. Defendant argued that she was, in effect, performing a necessary public service, because the same operation available to the rich at the city's private hospitals has been unavailable to the poor at D.C. General Hospital. The court, noting that this contention "has considerable support in the . . . statistics and other data presented," said that "national and local policy provide free medical care for the poor. It is legally proper, and indeed imperative, that uniform medical services be provided all segments of the population, poor as well as rich. Principles of equal protection under our Constitution require that policies in our public hospitals be liberalized immediately." Nonetheless, the court held that defendant was still liable to prosecution, because the powers of the State clearly bestow a right to control indiscriminate abortions, and denied her motion.

Doe v. Department of Transportation, U. S. Court of Appeals, Eighth Circuit, July 16, 1969; 38 L.W. 2090

The applicant was denied an airman third-class medical certificate by the National Transportation Safety Board on the basis of "a character or behavior disorder that is severe enough to have repeatedly manifested itself by overt acts," a Board regulation. The evidence of a character or "behavioral disorder cited included information of the applicant having been given an undesirable discharge from the Army in November 1957, of the Army's diagnosis of an "antisocial personality," of his homosexual episodes for ten years, including a 1965 conviction for sodomy, of his theft of Government property, of his traffic violations for reckless driving causing an accident and speeding, and of a mental examination interview (given at the request of the Administrator of the National Transportation Safety Board) which indicated a present desire to continue homosexual activity and contained a diagnosis of "sociopathic personality disturbance, dysocial type."

The Court of Appeals upheld the decision of the National Transportation Safety Board. The Administrator, the court said, evidently was "impressed with the fact that character and behavior disorders ordinarily are not subject to eradication by treatment and by the tendency of the disorder repeatedly to evidence itself. We detect no requirement that the disorder, to be disqualifying under the regulation, must be currently manifest. . . ." Further, the court added that "[w]hen a case is not in the criminal area one is naturally cautious for fear of punishing or depriving because of past acts. The regulation of air commerce, however, and the enforcement of the safety features of that regulation are not punitive to the extent they deprive. The justification is the general safety not only of the applicant but of the public. The rights and needed protection of that public are the proper subject of concern."

Adams v. Laird, U. S. Court of Appeals, District of Columbia Circuit, December 12, 1969; 38 L.W. 2347

An Executive Order provided that while in the possession of private industry classified information relating to the national defense must be protected. A Department of Defense directive implementing this Order provided that "no person is granted, or is allowed to retain, an authorization for access to classified information unless the available information justifies the findings that such access authorization . . . is clearly consistent with the national interest." On the basis of this directive the Central In-

dustrial Personnel Access Authorization Board denied access to classified defense information to a private defense contractor's homosexual technician.

On appeal by the technician, the Court upheld the Board's determination. The Board's finding of repeated homosexual acts by the technician justified it in declaring its inability to find that the granting of clearance was "clearly consistent with the national interest," the Court said. There is no constitutional requirement, the court added, that the President must, in seeking to safeguard the integrity of classified information, provide that a security clearance be given unless it is affirmatively proven that the applicant would use it improperly. The standard employed was declared not lacking in a "particularized enunciation adequate to satisfy due process elements of notice and rationality." Further, the court said that the Defense Department criteria "include[d] ample indications that a practicing homosexual may pose serious problems for the Defense Department in making the requisite finding for security clearance. They refer expressly to the factors of emotional instability and possible subjection to sinister pressures and influences which have traditionally been the lot of homosexuals. . . ."

A dissenting judge (Wright) said that "[n]o rational connection between isolated homosexual activity and reliability for security clearance purposes is demonstrated by . . . unsupported assumptions. Since the technician freely told of his homosexual experiences, his . . . homosexuality after this publicity is certainly no longer a basis for blackmail, if indeed it ever was. The technician was denied his clearance simply because of homosexual acts, without any effort to determine whether his status as a homosexual related to his ability to protect classified information."

Fhagen v. Miller, U. S. District Court for the Southern District of New York, December 4, 1969; 38 L.W. 2343.

Petitioner, a former patient in a mental hospital, sought to have adjudicated his claim that the New York mental commitment statute violates the due process clause of the Fourteenth Amendment of the United States Constitution by failing to provide judicial review sooner than 21 days after commitment upon petition of a layman. The State Commissioner of Mental Hygiene, in this proceeding, called into question the right of plaintiff to bring this action.

The court allowed the suit, finding that plaintiff, although not presently a patient in a mental hospital, did not lack standing to sue, in part because of his medical history of two prior confinements. The New York State commitment procedures, the court said, involve issues of the adequacy and reasonableness of notice to the confined person or to others in his behalf, the right to a reasonably prompt hearing as to the validity of his detention, the reasonableness of a period of temporary detention until hearing, and the availability of judicial or other adequate review, issues not foreclosed by existing controlling authority.

Goldwater v. Ginzburg, U. S. Court of Appeals, Second Circuit, July 18, 1969; 38 L.W. 2095

Publisher Ginzburg devoted an entire 1964 issue of *Fact* magazine to an examination of whether Senator Goldwater was psychologically fit to be President. A letter and questionnaire were sent to a list of psychiatrists, inviting them to answer, with their comments, the question, "Do

you believe Barry Goldwater is psychologically fit to serve as President of the United States?" While the poll was being conducted, psychiatrists and the American Psychiatric Association sent letters to the publisher denying the validity of the project. The article's central theme was that the candidate suffered from paranoia. The conclusions in the article were never evaluated by any expert in the field of psychiatry.

Senator Goldwater sued Ginzburg and *Fact* magazine, alleging libel. The trial court found defamation, and awarded the Senator both compensatory and punitive damages. On appeal, the Court of Appeals affirmed.

Regardless of how erroneous and offensive the publication was, the court said, the Senator is not entitled to recover unless he can prove that the publication "was made with actual malice—that is, with knowledge that it was false or with reckless disregard of whether it was false or not." It found that from the totality of appellants' conduct a jury reasonably could find a predetermined and preconceived plan to malign the Senator's character. The Court made mention of the following facts: that letters mailed by Ginzburg cast aspersions on the candidate's character; that the article stressed that Goldwater had suffered two nervous breakdowns, although these had been denied; that thearticle deleted statements favorable to the Senator; and that there were innuendos and numerous statements quoted out of context.

The material in this section is based on summaries prepared by the Legislative Services Branch, Office of Program Planning and Evaluation, NIMH.

Mental Health News Digests

Recovery, Inc.

Recovery, Inc.—the association of nervous and former mental patients—is now in its 33rd year of community service as a national program for about 800 groups throughout the United States and Canada. Founded in 1937 by Abraham A. Low, M.D. of the Psychiatric Institute of the University of Illinois Medical School, Recovery, Inc. has the purpose "To prevent relapses in former mental patients and chronicity in nervous patients." It was professionally supervised by Dr. Low until 1952 when it became a self-help organization. It is nonprofit, nonsectarian, self-supporting, and self-governing.

Recovery's program provides a systematic method of self-help aftercare for both nervous and former mental patients. Group leaders are members specially trained in the Recovery Method who volunteer leadership at group meetings. The focus is on achieving conscious self-control to reduce anxiety, fear, or hostility.

Meetings are usually held weekly in groups of about 20 or fewer persons. There is no charge for attendance, but a collection is taken. For those who join, there is an annual $5.00 membership fee. Many participants are referred by physicians, as well as clergymen, social workers, and others. Members of the family may attend but do not participate in the discussions.

Recovery, Inc. emphasizes that it does not "advise, counsel, diagnose, or treat." Members remain under the care of their personal physicians or other professionals at all times.

Recovery offers, on request, a one-hour demonstration panel, providing a picture of how it functions; a pamphlet, "Recovery, Inc.—Offering a Systematic Method of Self-Help After-care" is also available.

Recovery National Headquarters is located at 116 South Michigan Ave., Chicago, Ill. 60603.

American Foundation for Autistic Children

The American Foundation for Autistic Children was established in 1967 as a national nonprofit organization to promote the welfare of autistic children. Its purpose is to help meet the needs of autistic children and to promote research and knowledge on ways to prevent autism and to ameliorate this condition in children who are its victims. The general aims of the Foundation are to provide therapeutic training for afflicted children; help educate parents in training methods for application at home; support programs for training personnel in the care, training, and treatment of autistic children; advance research; and improve public understanding. The address of the Foundation is 1701 Pennsylvania Ave., N.W., Suite 407, Washington, D.C. 20006.

Associated Faculties Program in Community Psychiatry

The Associated Faculties Program in Community Psychiatry offers postgraduate instruction to psychiatrists and organizes its faculty and student body in research projects involving community mental health. It is a joint project of the faculties of the 12 major psychiatric teaching institutions in the Washington, D.C. area, and is probably the first of its kind.

Founded by members of a study seminar at the Washington School of Psychiatry concerned with community psychiatry and heads of local

teaching institutions interested in a collaborative educational program in the field, its first tasks were to build a teaching program leading to a certificate and to form a study group to supervise the teaching program and explore developments in community psychiatry. The study group is the policy-making body of the program. It is made up of representatives of the participating institutions—Georgetown, George Washington, and Howard Universities, Chestnut Lodge Sanitarium, the District of Columbia Health Department, Children's Hospital, St. Elizabeths Hospital, Bethesda Naval Hospital, Walter Reed General Hospital, the Washington Psychoanalytic Institute, the Washington School of Psychiatry, and the National Institute of Mental Health. Currently it is administered by a full-time executive secretary and by three psychiatrists who work part time as chairman, director of curriculum, and director of field studies.

The teaching program began in the fall of 1965 with 23 psychiatrists enrolled as students. The course continues over a two-year period and consists of one two-hour session a week for 28 weeks a year, plus practicum. The first year is given over to a reading-discussion, and the second year consists of interrelated seminars that concentrate on community dynamics and the ways psychiatrists intervene professionally in the community. More than 100 psychiatrists are involved with the program, and it has had a significant impact on mental health developments in the Washington area. The Area C Mental Health Center, the first complete mental health center in D.C., is being developed by graduates of the program. The seminar has served as a consultant group for several organizations.

Certain trends and developments have influenced the direction of the program. Because elements of the courses are used as models for staff and resident training in member institutions, the goals of the program must continually be reformulated. For example, as member institutions have increased training in the practical aspects of community psychiatry, the program has shifted its emphasis to the more theoretical aspects, focusing on sociology, community structure, and group theory. Changes in the seminar are also being considered.

Robert G. Kvarnes, M.D., is Chairman; Louis F. Rittelmeyer, Jr., M.D., is Director of Field Studies; Irving Schneider, M.D., is Director of Curriculum; and Barbara O. Taylor is Executive Secretary. (Adapted from *Hospital & Community Psychiatry,* February 1970.)

Mental Health Information Service in New York

The Mental Health Information Service was established in 1965 in the State of New York as an arm of the court independent of the Department of Mental Hygiene. Its responsibilities are to study and review admission and retention of involuntary patients, and to inform the patients and others about admission and retention procedures and rights to hearing and review, to legal counsel, and to independent medical opinion. This Service is the first of its kind.

Representatives of the Service appear at court hearings to provide background information on patients, including recommendations for alternate care. There are four judicial departments in the State, with headquarters in Manhatten, Brooklyn, Albany, and Rochester, in addition to local offices in the hospitals. Staff is made up primarily of lawyers and social workers.

Since it was started, its duties have been expanded to include service to

all patients under 21 and to participate in proceedings involving patients' fiscal matters. It has also been involved in patients transferring from involuntary status to voluntary status and in protecting the rights of the criminally mentally ill.

The Service begins its work with a patient at the time of admission to insure that his constitutional and civil rights are protected and to help the court make an impartial decision on the need for hospitalization. Upon admission, the patient's case is reviewed after 60 days, six months, one year, and then at two-year intervals. A patient may ask for a hearing and a jury trial at any time. Many hospitals now have court rooms, which helps to emphasize the fact that the hearings are judicial proceedings.

Real Great Society

An interesting community-developed program is the Real Great Society, Inc., which was started in New York City to help business enterprises of youth in the ghetto. It is directed by a board made up completely of young people under age 20. Its goals include developing a clothing manufacturing firm with a retail outlet, developing an economic development planning studio, and providing community services.

American Academy of Psychiatry and the Law

A new organization—the American Academy of Psychiatry and the Law—has been formed, devoted to advancing the field of forensic psychiatry. Its officers are Drs. Jonas Rappeport, president; Joseph Satten, vice-president; Herbert Thomas, secretary; Ames Robey, treasurer; and Melvin Heller, Seymour Pollack, John MacDonald, John Suarez, councilors. Chairman of the membership committee is Dr. Robert Sadoff and of the program committee, Dr. A. Louis McGarry.

Change in Internship Requirement

The American Board of Psychiatry and Neurology no longer requires the internship for specialty certification. In changing the requirement, the Board emphasized that it is not against the principles of internship, but that it did wish to foster innovation in medical education. In line with this change, the National Institute of Mental Health has dropped the internship requirement for training stipends. Many training centers still require the internship before residency, but the trend seems to be toward eliminating the internship in psychiatry as well as other medical specialties.

Young Volunteers in Pennsylvania

In Pennsylvania, young people, individually or in groups, donated over 54,000 hours of time to mentally disturbed or retarded patients in State schools and mental hospitals during FY 69. A total of 7,210 junior and college volunteers participated in various programs of service appropriate to their age. They worked under the direction of program staff through volunteer resources coordinators. Some 2,789 students from approximately 100 colleges throughout the State gave 19,339 hours of service to the program from July 1968 to June 1969. A total of 4,421 youths over 16 years of age donated 35,418 hours of service as Junior Volunteers. The young people, with parental permission and following supervised orientation and training, perform the same wide range of volunteer services as do adults, but within their age capabilities. Services range from planning holiday parties and entertainment to tutoring and individualized services.

Valiance House

"Valiance" is the acronym for "Volunteer Addicts Living in a New Creative Environment," and Valiance House is a new treatment center in a wing of the Mitchell Building at Norwich (Conn.) Hospital.

The program will be in three phases: detoxification, therapy, and rehabilitation at the community level. Residents, all male at the outset although facilities for females are being prepared, will be called "family members." All will share responsibility for the house. Continuing of education will be encouraged under the educational program. Staff with specialized training will be at the House on a 24-hour basis. The program was developed by William R. Sides, Ph.D., who will be director of the center.

Certificate in Drug Abuse Counseling

A nine-credit certificate program is being offered at the University of Minnesota to train individuals to assist professional counselors working with drug abuse, alcoholism, and related problems. The evening classes are given by the schools of Public Health and Social Work and the Division of Pharmacology and offered through the General Extension Division. Students must also complete an internship to earn a certificate; local hospitals, the VA, the treatment centers for drug abuse are cooperating in offering the internships.

Canada's Mental Health

Canada's Mental Health was started 18 years ago by the Mental Health Division of the Department of National Health and Welfare. Published in English and French, its purpose is to assist the provinces and their professional personnel in the development and promotion of mental health services. It is the only interdisciplinary mental health journal in Canada and is distributed on a complimentary basis in Canada to clinics, hospitals, university departments of psychiatry, psychology, social work, nursing, and to public health clinics, welfare agencies, guidance personnel, and others involved in the mental health field. For foreign subscribers the subscription fee is $3.00, payable to the Receiver General of Canada, c/o The Queen's Printer, Ottawa, Canada. The current international subscription list is about 22,000. The journal also issues supplements, such as bibliographies, special reports and directories. A list of available supplements may be obtained from the Editor.

Succeeding Carl Birchard, M.S.W., who was editor since 1955, Barry Katz, M.S.W., has been named editor beginning in January 1970. All correspondence (except foreign subscriptions) should be addressed to the editor at the Mental Health Division, Department of National Health and Welfare, Ottawa, Canada.

Community Mental Health Centers Amendments of 1970

The Community Mental Health Centers Amendments of 1970 were signed into law by President Nixon on March 5, 1970. The law provides for the extension of the Federal program for community mental health centers, as well as for the alcoholism and narcotic addiction programs, for three years, i.e., through Fiscal Year 1973.

A significant new program was added. The amendments provide grants for construction, staffing, training, and evaluation of *mental health services for children*. Moreover, there is a special requirement that these programs must make available "a full range of treatment, liaison, and follow-up services" for children and

their families in their respective service areas. Also, upon request they must provide consultation and education for all school personnel and other community agencies serving children in the area. The inclusion of "liaison" and "follow-up" as elements of a satisfactory program adds two "essential elements" for children's services, to the five "essential elements" (inpatient service, outpatient service, partial hospitalization, emergency service, and consultation and education) required for community mental health centers.

Another new feature of the amendments is a provision for grants for consultation services. An additional grant may be made to centers receiving a staffing grant to pay the salaries of professional or technical personnel who will be providing consultation services. The Federal share cannot exceed whichever is lower of the following: 15 percent of the costs covered by the regular staffing grants *or* the difference between the percentage covered by the regular grant and 100 percent.

Another new feature is direct grants for *special projects* on training and evaluation in the alcoholism program. These grants are similar to those now available in the narcotics addiction program. Also, the new law specifies that the funds may be used for demonstration of new or particularly effective methods of delivery of services in both the alcoholism and the narcotics addiction programs but not in the program for children.

The maximum Federal share of costs for construction grants under all four programs was set at 66⅔ percent of costs, except that in poverty areas it is 90 percent.

For staffing grants in the basic community mental health centers the maximum Federal share was set at 75 percent of costs for the first two years, 60 percent for the third year, 45 percent for the fourth year, and 30 percent for each of the next four years. However, in poverty areas the maximum is 90 percent for the first two years, 80 percent for the third year, 75 for the fourth and fifth years, and 70 percent for each of the next three years. In the programs for alcoholism, narcotics addiction, and mental health services for children, the maximum Federal share is 80 percent of costs for the first two years, 75 percent for the third year, 60 percent for the fourth year, 45 percent for the fifth year, and 30 percent for each of the next three years. In poverty areas the maximum is the same as that for the basic center grants. The duration of all staffing grants is now eight years.

Staffing costs are still limited to compensation to professional and technical personnel, but there is a new definition of the term "technical personnel" which is applicable to all those who perform technical functions except minor clerical personnel and maintenance and housekeeping personnel.

All construction and staffing grants for all programs must be recommended by the National Advisory Mental Health Council.

The Secretary of DHEW must make a determination of which areas should be designated as poverty areas. They may be either rural or urban, and the entire area need not be impoverished in order to qualify. An area cannot be disqualified because some of its population is affluent, if it has one or more subareas that meet the poverty standard, a "significant portion" of the population of the total area lives in these subareas, and the center will serve the needs of these people.

The authorized appropriations are:

Basic community mental health center grants

Construction: $80 million for FY 1971; $90 million for FY 1972; $100 million for FY 1973

Staffing: $45 million for FY 1971; $50 million for FY 1972; $60 million for 1973

Alcoholism grants

Single appropriation for construction, staffing, and direct grants for special projects: $30 million for FY 1971; $35 million for FY 1972; $40 million for 1973

Narcotics addiction grants

Same as alcoholism grants.

Mental health services for children grants

Single appropriation for construction, staffing, and training and evaluation: $12 million for FY 1971; $20 million for FY 1972; $30 million for FY 1973

Consultation services for all four programs

$5 million each year for FY 1971, 1972, and 1973

It should be noted that although these figures represent authorized appropriations, the funds do not become available until the appropriations bills for the specific fiscal years have been passed by the Congress and signed by the President.

recent nimh publications

Single copies of these publications may be obtained from the Office of Communications, National Institute of Mental Health, LL02, 5454 Wisconsin Ave., Chevy Chase, Maryland 20015. A complete list of all publications available from the NIMH may also be obtained from the Office of Communications. If a price is given, the publication may be ordered in quantity from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Enclose a check or money order payable to the Superintendent of Documents.

Mental Health Directory: 1970. This 445-page directory lists regional mental health offices of the Department of Health, Education, and Welfare; mental health offices in the States; mental health services and facilities in the States and communities; mental health associations; and other sources of mental health information. National Clearinghouse for Mental Health Information Publication No. 1005. $4.00. (Available primarily from the Superintendent of Documents. Gratis copies available in very limited supply.)

Mental Health Program Reports—4. Detailed descriptions of 16 research programs or projects are provided in this 333-page publication: biological rhythms and the pineal gland, why adolescents kill themselves, serving an urban ghetto through a community mental health center, clinical studies in alcoholism, behavioral consequences of alienation, characteristics of riot participants, interdisciplinary studies of manic-depressive psychoses, alternatives to violence, genetic factors in mood disorders, hypnosis: a respectable tool for medicine and psychology, changes in role concepts of police officers, the rural nurse as a crisis counselor, the impact of visual media on personality, reducing the effects of cultural deprivation. Prepared by the Program Analysis and Evaluation Branch, Office of Program Planning and Evaluation, NIMH. National Clearinghouse for Mental Health Information Publication No. 5026. $1.75.

An Administrator's Handbook on the Application of Operations Research to the Management of Mental Health Systems. The intent of this 67-page handbook is to introduce mental health administrators to a group of techniques known as operations research which can help in making optimum administrative decisions. Chapter I describes the process and methods, Chapter II contains examples of techniques, Chapter III presents hypothetical examples suggesting potential uses, and Chapter IV contains suggestions for introducing and conducting an operations research program. Prepared by the Systems Research Section, Applied Research Branch, Division of Extramural Research Programs, NIMH, National Clearinghouse for Mental Health Information Publication No. 1003. 35¢.

A Federal Source Book: Answers to the Most Frequently Asked Questions About Drugs. "This [42-page] publication presents the latest scientific answers to some of the questions most frequently asked about drug misuse. For the first time, all of the concerned Federal agencies and departments have pooled their knowledge to produce a single source book on the national drug problem. The answers are based upon the latest research findings of the National Institute of Mental Health and are presented in accord with the policies and programs of the Defense Department, the Department of Health, Education, and Welfare, the Department of Justice, the Department of Labor and the Office of Economic Opportunity." (Quoted from the introductory statement by President Nixon.)

Drug Dependence, December 1969. This is the second experimental issue of a new publication designed to facilitate dissemination and exchange of information in the field of drug dependence and abuse and to provide abstracts of the current literature. 50¢.

Marihuana Fables and Facts. This is a little 4-page flyer listing 10 "fables" and facts about marihuana. National Clearinghouse for Mental Health Information Publication No. 5021. 5¢, $2.00 per 100.

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